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DELAYS IN MEDICARE PAYMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

JULY 11, 1986, MIAMI, FL

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DELAYS IN MEDICARE PAYMENT

FRIDAY, JULY 11, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
Miami, FL.

The subcommittee met, pursuant to notice, at 9 a.m., in the County Commissioners' Hearing Room, 111 Northwest First Street, Miami, FL, Hon. Claude Pepper (chairman of the subcommittee) presiding.

Members present: Representatives Pepper, Bilirakis, Fascell, and Larry Smith.

Staff present: Kathleen Gardner-Cravedi, staff director; and Melanie Modlin, assistant staff director.

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

Mr. PEPPER. The committee will come to order, please.

We are very grateful this morning to all of you who have come here to participate in this important hearing.

I am very much pleased that my distinguished colleague, the Honorable Dante B. Fascell, is here with me, and we anticipate, a little bit later, the arrival of another one of our distinguished Florida colleagues, the Honorable Mike Bilirakis.

In 1965, when we passed the bill providing for Medicare, Mr. Fascell will recall that we thought we had pretty well provided for the medical care of the elderly people of this country. At that time, they were paying about 20 percent of their gross income for their medical care, and we thought we were offering them relief from this burden.

Unhappily, as events have evolved, today they are paying more than 20 percent of their gross income for their medical care, in spite of this wonderful contribution that Medicare does make for the protection of the health and the promotion of the happiness of the elderly people of this country.

There has been a constant increase in the cost of medical care to the people covered by the Medicare Program—for example, the deductible.

When we started in 1965, the deductible was simply intended to be enough to keep people from going into the hospital over the weekend for sort of a health vacation. I think it was way down around $50, or something like that.

Now, if an elderly person covered by Medicare has to go to a hospital, it will cost him or her $492, and they were recently trying to

raise it to $575. We were able to stop it at just a little over $500 for the next increase.

So, you see how much has been added to the cost of the program for the elderly. They are constantly having to pay more for the part B, that is the doctor's part, of the Medicare Program.

And beginning with the first year of this administration, there came about cuts in medical services for the elderly people, and those cuts have continued.

A little while ago, when we had up the so-called Gramm-Rudman bill, I was on the conference committee. In that conference committee, we were able to get an exemption for Social Security; and I tried my best, in fact I had a recorded vote in the conference to prevent the reduction of administrative costs in the Medicare Program. I lost, unhappily, by a small majority in the conference, and consequently, since that time, the trouble that we have today is partially due to the effort to restrain or reduce administrative costs.

In Florida, we are very particularly affected by the delay of the payment of the claims of Medicare patients and to the providers of Medicare services.

One out of every fifteen Medicare patients in the United States lives in Florida, about 2 million people, and today the indebtedness, the amount in arrears by the Medicare administration to the proper claimants of Medicare benefits' providers and recipients, is something like $300 million.

We have a case, for example, of a lady who was mugged—her jaw, her nose, and her ankles broken. She had to pay all the expenses, and she was not able to get reimbursement from Medicare. Finally, a year elapsed, and she did not have any more money. She had to move from Miami Beach to New York to live with her daughter.

We will have another case of a man who had a severe heart attack. He incurred expenses of some $2,000 out of his own pocket because he could not get the claims paid otherwise, and he wondered what was happening to him. He said that dealing with the Medicare people is like coming up against a stone wall.

We will have doctors here today who have testified that they have had to go into bankruptcy because they had 100,000 dollars' worth of claims, of bills, properly assessed against Medicare that have not been paid by Medicare.

Some other providers here today will tell us about their own experiences. Some of them had to go into bankruptcy because they could not get the payment of the claims that they were entitled to receive.

Now that is an outrageous condition, and we are going to hear from the people who know something about this matter today as to what can be done to correct the present situation and diminish occurrence in the future.

For example, we will have the Blue Cross/Blue Shield representatives here. On the whole, they have done an excellent job. I have noted with pleasure the excellence of their performance now for quite a while. It is not their fault. I think it is the fact that they are not getting the money to distribute, and they will tell us about that today. Mr. Fascell and I, after we get the advice of knowledge-

able people here today we will seek, if we can, to get an adjustment made in Washington so they will have to be given this money.

We have been in touch with the proper committees that are knowledgeable about the sources of money, and they tell us there is enough money for these claims to be paid if we will simply provide it reasonably enough in advance so that the mechanism can operate to get the money into the hands of the beneficiaries who should receive it.

In respect to Medicare the law provides that all claims shall be paid in 30 days. I regret to tell you about this, and somebody may mention it in his or her testimony here today, but we recently learned that the Medicare people were lending out some of the money that should have been paid to beneficiaries in order to accumulate interest on that money to the principal of the sum. Well, that money needs to go to the people for whom it is intended, and that is why we are here today, to see if we cannot assure that that will be done.

So now, without objection, I would like to insert for the record a statement of mine, a written statement, and I would like to ask my distinguished colleague, Mr. Fascell, for such comment as he would like to make.

[The prepared statement of Chairman Claude Pepper follows:]

PREPARED STATEMENT OF CHAIRMAN CLAUDE PEPPER

MEMBERS OF THE SUBCOMMITTEE. LADIES AND GENTLEMEN. TODAY'S HEARING IS TREMENDOUSLY IMPORTANT. IT COMES AT A TIME WHEN THE CONGRESS AND THE ADMINISTRATION ARE LOOKING FOR WAYS TO REMEDY THE ANTICIPATED SOLVENCY PROBLEMS FACING MEDICARE. IT COMES AT A TIME WHEN WE ARE TRYING TO IMPROVE MEDICARE'S COVERAGE FOR SENIORS. AS WE ATTEMPT TO ACCOMPLISH THESE NOBLE OBJECTIVES, IT IS IMPERATIVE THAT WE FIRST SCRUTINIZE THE ADEQUACY AND EFFECTIVENESS OF HEALTH INSURANCE CURRENTLY AVAILABLE TO OUR NATION'S 28 MILLION OLDER AMERICANS, AND 3 MILLION DISABLED.

DOZENS OF HEARINGS BEFORE OUR SUBCOMMITTEE HAVE HIGHLIGHTED THE TREMENDOUS INCREASES IN MEDICARE SINCE ITS ENACTMENT IN 1965 -- IT HAS INCREASED NEARLY 3600%. SADLY, IT HAS ALSO RIPPED GIANT HOLES IN THE FIXED INCOMES OF OLDER AMERICANS WHO HAVE NOT KEPT PACE WITH THE RISING HEALTH CARE COSTS. SENIOR CITIZENS TODAY ARE SPENDING MORE OF THEIR INCOME FOR HEALTH CARE THAN BEFORE MEDICARE WAS ENACTED.

COUPLED WITH THE INCREASED COST OF SERVICES COVERED BY MEDICARE ARE THE BANKRUPTING COSTS ASSOCIATED WITH SERVICES NOT COVERED BY MEDICARE OR MOST PRIVATE INSURANCE FOR THAT MATTER. THE FACT OF THE MATTER IS THAT MEDICARE TODAY ONLY PAYS ABOUT 48% OF AN OLDER PERSON'S MEDICAL BILLS AND THE REST MUST COME OUT OF THEIR OWN POCKETS. AS LIMITED AS MEDICARE'S PROTECTION IS -- IT IS A GODSEND AND LITERALLY NO ONE WOULD HAVE IT ABOLISHED. SADLY, HOWEVER, THIS HEARING WILL DETAIL HOW THIS SHRINKING MEDICARE BENEFIT IS CURRENTLY UNDER ATTACK.

MEDICARE IS REQUIRED BY LAW TO PAY ITS BILLS WITHIN 30 DAYS. HOWEVER, WE HAVE FOUND THAT IN AN EFFORT TO SAVE THE MEDICARE PROGRAM MONEY, THIS ADMINISTRATION HAS DECIDED TO DISREGARD THE LAW FORCING MILLIONS OF OLDER AMERICANS, DOCTORS AND OTHER HEALTH PROVIDERS, TO WAIT 2 AND EVEN 3 MONTHS BEFORE PAYING THEIR MEDICAL BILLS. THIS IS ANOTHER IN A LONG LINE OF ATTEMPTS BY THIS ADMINISTRATION TO CUT AWAY AT THE MEDICARE PROGRAM -- IN THIS INSTANCE HOLDING MILLIONS OF FLORIDA'S ELDERLY AND HEALTH CARE PROVIDERS HOSTAGE -- THROUGH AN ACT OF BUREAUCRATIC LAWLESSNESS.

THESE FORCED DELAYS IN MEDICARE'S PAYMENTS HAVE RESULTED IN AN ASTONISHING BACKLOG OF UNPAID BILLS AROUND THE NATION. MEDICARE BENEFICIARIES AND HEALTH CARE PROVIDERS ARE NOW LEFT WITH NEARLY $5 BILLION IN CLAIMS FOR MEDICAL CARE WHICH THE GOVERNMENT HAS REFUSED TO PAY.

FOR MILLIONS OF OLDER AMERICANS LIVING ON FIXED INCOMES, DELAYED REIMBURSEMENT PRESENTS UNDUE HARDSHIP. SUCH DELAYS FUELS AN EXODUS OF PROVIDERS FROM TAKING MEDICARE PATIENTS. IN 1966, THE YEAR THAT MEDICARE WENT INTO EFFECT, OVER TWO-THIRDS OF ALL DOCTORS AGREED TO ACCEPT MEDICARE ASSIGNMENT. TODAY, ONLY ABOUT ONE-THIRD AGREE TO DO SO. THOUSANDS OF DOCTORS, HOME HEALTH AGENCIES AND HOSPITALS ARE ON THE BRINK OF FINANCIAL RUIN. MANY HAVE BEEN FORCED TO DECLARE BANKRUPTCY, AS WE WILL HEAR TODAY, AND GO OUT OF BUSINESS.

THE SITUATION IS PARTICULARLY ACUTE IN FLORIDA, WHERE ONE IN EVERY FIFTEEN MEDICARE BENEFICIARIES RESIDE. THESE 2 MILLION AGED AND DISABLED FLORIDIANS WHO ARE COVERED BY MEDICARE HAVE OUTSTANDING MEDICAL BILLS TOTALLING OVER $300 MILLION. THIS IS A NATIONAL DISGRACE.

LET ME PERSONALIZE THE PROBLEMS SOME SENIORS ARE FACING DUE TO MEDICARE PAYMENT DELAYS:

- AN EIGHTY YEAR OLD WIDOW FROM MIAMI RECENTLY WROTE TO ME. SHE TOLD ME SHE WAS THE VICTIM OF A SAVAGE MUGGING WHICH LEFT HER WITH A BROKEN ANKLE AND BROKEN NOSE. SHE HAS BEEN WAITING OVER HALF A YEAR FOR REIMBURSEMENT OF $1000 IN DOCTOR AND OTHER BILLS. BECAUSE SHE LIVES ON A FIXED INCOME, THIS WOMAN HAS BEEN FORCED TO MOVE TO NEW YORK TO LIVE WITH HER DAUGHTER. SHE SAID, "I FEEL LIKE I'M BANGING MY HEAD AGAINST THE WALL. MEDICARE TREATS ME LIKE I HAVE THE PLAGUE."

- AN ELDERLY GENTLEMAN FROM FLORIDA SUFFERED A SERIOUS HEART ATTACK. HE HAS BEEN WAITING 3 MONTHS FOR MEDICARE TO PAY HIM NEARLY $2000 OWED HIM FOR DOCTOR BILLS. HE TOLD ME, "THEY ARE HOLDING MY MONEY HOSTAGE. IS THIS GOING TO BE THE SIGN OF THINGS TO COME WITH MEDICARE?"

- A DOCTOR FROM MIAMI TOLD ME THAT HE HAS BEEN FORCED TO GIVE UP HIS PRACTICE OF TREATING MEDICARE PATIENTS AND DECLARE BANKRUPTCY DUE TO OVER $100,000 IN UNPAID MEDICARE CLAIMS.

- AN ESTABLISHED MIAMI BUSINESS PROVIDING NEEDED DURABLE MEDICAL EQUIPMENT SUCH AS WHEELCHAIRS TO THE ELDERLY WHO ARE HOMEBOUND WAS ALSO FORCED TO DECLARE BANKRUPTCY. THIS COMPANY NOW HAS ROUGHLY THREE-QUARTERS OF A MILLION DOLLARS IN BILLS MEDICARE HAS NOT PAID.

I HAVE HEARD LITERALLY HUNDREDS OF SUCH SAD TALES IN RECENT MONTHS. IN MAY, I WROTE TO THE HONORABLE OTIS BOWEN, THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES URGING HIM TO RESTORE THE PAYMENT CYCLES AND POLICIES OF MEDICARE. ALTHOUGH I AM PLEASED TO REPORT THAT THE DEPARTMENT HAS RECENTLY ANNOUNCED THE RELEASE OF SOME $15 MILLION NATIONWIDE TO HELP SPEED UP MEDICARE CLAIMS PROCESSING -- WE HAVE NOT RECEIVED ASSURANCES THAT THIS PROBLEM WILL NOT BE REPEATED. ALSO, WHILE LEGITIMATE CLAIMS WILL NOW HAVE TO BE PAID, THE DAMAGE ALREADY FELT BY PROVIDERS AND BENEFICIARIES WILL BE HARD TO OVERCOME -- AND THIS ISSUE REMAINS TO BE ADDRESSED BY THIS ADMINISTRATION.

I HAVE BEEN IN CONSTANT CONTACT WITH THE APPROPRIATIONS COMMITTEE TO ENSURE THAT THERE IS ADEQUATE FUNDING TO CLEAN UP CURRENT BACKLOGS AND PREVENT THIS PROBLEM FROM HAPPENING AGAIN. BUT IT WILL TAKE THE VIGILENCE OF THE AMERICAN PEOPLE AND THE CONGRESS TO ENSURE THAT THIS PROBLEM IS NOT REVISITED IN 1987.

TODAY WE WILL HEAR THE TESTIMONY OF ELDERLY FLORIDIANS VICTIMIZED BY MEDICARE PAYMENT DELAYS, FROM HEALTH CARE PROVIDERS FORCED TO DECLARE BANKRUPTCY DUE TO SUCH DELAYS, FROM REPRESENTATIVES OF BLUE CROSS AND BLUE SHIELD AND AETNA -- WHO ARE CHARGED WITH THE RESPONSIBILITY FOR PROCESSING AND PAYING MEDICARE'S BILLS. BOTH BLUE CROSS AND BLUE SHIELD AND AETNA SHOULD BE COMMENDED FOR THEIR EXPRESSED COMMITMENT TO PROCESS BILLS AS QUICKLY AS POSSIBLE. WE WILL ALSO HEAR FROM THE REGIONAL HEAD OF THE U.S. HEALTH CARE FINANCING ADMINISTRATION, THE FEDERAL AGENCY RESPONSIBLE FOR ADMINISTERING THE MEDICARE PROGRAM. WE HOPE HE WILL EXPLAIN HOW THE ADMINISTRATION PLANS TO PREVENT THE RECURRENCE OF THIS SAD SITUATION AND HOW THEY PLAN TO REPAY THE DAMAGES ALREADY SUSTAINED BY THOUSANDS OF ELDERLY AND HEALTH CARE PROVIDERS IN FLORIDA AND NATIONWIDE.

THANK YOU. WE LOOK FORWARD TO TODAY'S TESTIMONY.

STATEMENT OF REPRESENTATIVE DANTE B. FASCELL

Mr. FASCELL. Mr. Chairman, thank you very much.

First of all, let me add my commendation to many others for you as chairman of the Subcommittee on Health and Long-Term Care, for calling these hearings and making a record on this matter.

We are all very grateful to you because of the lifetime of commitment to not only the elderly, but to the welfare of the citizens of our country, both in terms of health and other matters. This is a natural followup of something you have been doing all your life. We are very grateful for that.

These hearings will make a very important record because we have, it seems, a constant problem, and, at this particular point, it has been aggravated. Let's call it the problem of the three too's.

As long as I can remember in dealing with this subject, whether it is Medicare, the Home Health Agency, or anything that has to do with Federal participation involving the care and concern of our citizens, it has taken too long to get reimbursed. There has been too much paper work involved in getting the reimbursement, and the whole program has been too costly to the beneficiary.

Now, as long as those three too's are there, we, all of us, have a constant problem.

I was delighted to hear the chairman, and I join him, in saying that this is not simply a matter of pointing the finger at processors, or at providers, or at paperwork, or even at those who provide the money.

I would think, and would be very interested in following up this matter, and I certainly join with you, Senator, in your efforts, that perhaps one of the things we ought to consider is getting the administrative money in sufficient amounts up front. Maybe the way to do that would be to do it on a 2-year cycle, and that would be my suggestion.

So, I congratulate you. I am delighted to be here. I appreciate you letting me sit in as you open these hearings, even though I am not a member of your subcommittee. But we are good friends; we work together. This is a serious problem, and we are going to do our best to help solve it.

Mr. PEPPER. Well, you were a natural participant in this occasion, Mr. Fascell, because you have been a great leader in the cause of the elderly, as well as the cause of the people generally, all of your public life; and you and I are going to get hold of some of these problems today so that when we get back to Washington we can try to straighten some of these things out.

Now then, we are very grateful for our panel——

Oh, I beg your pardon, I did not notice that our distinguished colleague, Mr. Mike Bilirakis, from over on the west coast, is here with us today.

I had invited all the members of the Florida delegation to join with us in this hearing because it affects all parts of Florida, and I am delighted that Mr. Bilirakis has come to join us here today.

Thank you very much, Mike.

STATEMENT OF REPRESENTATIVE MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman. I have a brief statement, sir. I would wish you and my distinguished colleague, Mr. Fascell, a good morning. I am especially pleased to be with you today as we undertake this issue of immense importance to all Floridians.

I would also like to take a moment to gratefully acknowledge, Mr. Pepper, my thanks for inviting me to be a part of today's hearing. It is always a pleasure to serve with you, and especially so today.

Although, as many of you know, I could not retain my seat on the Select Committee on Aging and simultaneously serve on the Energy and Commerce Committee in this 99th Congress, I, nonetheless, continue to be most concerned about and active in all matters affecting the health and well-being of our Nation's elderly citizens.

As a member of the Energy and Commerce's Health and Environment Subcommittee, and, as you know, sir, that is basically the chief legislative committee in this area, I have an opportunity to become involved in all of the major health issues of the day, including, of course, Medicare.

I would like to share with you, sir, and with our audience some happenings basically in my district.

Several weeks ago, I, like most Members of the Florida delegation, began receiving letters from constituents telling me of their unfortunate experiences in receiving reimbursement for Medicare claims they had filed. Most did not want their cases looked into on an individual basis but, rather, wanted to take the time to inform their representative in Congress of the desperateness of the situation and the hardship that these delays were causing our elderly.

I read letter upon letter telling me how much my constituents needed and depended upon the reimbursements they were due from Medicare and how rent, utilities, and even food often had to wait as a result of the claims processing delays.

These expressions of concern led to my contacting Florida Blue Cross/Blue Shield to inquire about the reasons for the delays.

I was informed by the carrier that they are experiencing a backlog due to a record number of claims received from the winter months—and this is July—when Florida traditionally receives an influx of veterans.

Blue Cross/Blue Shield stated that the $1.3 million reduction in funding that they had to take under the Gramm-Rudman deficit reduction legislation, and I hope we can go into that some while here today, sir, which I voted against, by the way, prevented them from hiring additional employees to meet their increase in claims.

Thus, I was told, they have not been able to maintain the same service levels which Medicare recipients had been accustomed to; and the 2-week turn around, which had been their average, had now become one of approximately 60 days or more.

The carrier assured me on that day that they were doing everything possible to expedite the processing of claims. As we found out later, however, other factors may also be at work; and I am sure

you have addressed these and will continue to address these, Mr. Chairman.

The Health Care Financing Administration [HCFA], which has national jurisdiction over the Medicare Program, has, in fact, recently initiated a deliberate policy, I understand, of slowing down payments to Medicare recipients and providers in order to accumulate the interest on the funds.

Now, as a fiscal conservative, I wholeheartedly support all reasonable deficit reduction measures and will continue to do so. At the same time, however, I strongly feel that the budget should not be balanced on the backs of the elderly of our country. Let everyone share in the responsibility equally.

The elderly, who have worked a lifetime's hard labor, through wartime, depression, and recession, should not be asked to shoulder an unfair amount of the deficit reduction burden.

It is my strong belief that when you ask a senior citizen, living and depending only on a monthly Social Security check, to wait, sometimes for more than 2 months, to receive reimbursement on a medical bill when he needs that money to buy food to eat, you are, indeed, asking him to shoulder an unfair amount of the burden.

For this reason, Mr. Chairman, I am pleased to have become a cosponsor of legislation pending in the Congress, H. Res. 468 and H. Res. 471, expressing the sense of the House regarding Medicare payment processing.

If HCFA does not voluntarily abide by those two resolutions, the legislation encourages the House to enact legislation to assure the claims are paid in a timely manner. These bills also urge the House, as you know, to authorize sufficient fiscal year 1987 funds for claims processing and beneficiary and provider services.

I sincerely hope, Mr. Chairman, that those particular legislative measures, along with the companion measure introduced by Lawton Chiles in the Senate, as well as initiatives like today's hearing, will soon become effective in reversing this slowdown policy.

Thank you very much, Mr. Chairman.

Mr. PEPPER. Well, thank you very much.

You have made reference to legislative bills that have been introduced. I have introduced also H.R. 4287, which, we think without requiring additional payment of money, can give prompt and effective service to the Medicare beneficiaries over the United States.

Mr. Bilirakis, you have been a true friend of the elderly, have worked diligently, like Mr. Fascell, in their service, and so it is characteristic of your interest that you would be here with us today. We are grateful, sir, for you being here.

I would also like to present to the audience the distinguished director of our Subcommittee on Health and Long-Term Care, Ms. Kathy Gardner.

Now, the first panel will be the panel entitled "Medicare Beneficiary Victims." First, we will have Mrs. Dorothy Morrison of Coral Gables; then Mr. Alexander Bookstaver, Miami Beach; and finally Mr. Earl Bourdon of Claremont, NH, a board member, National Council of Senior Citizens. Last time I saw him was in New Hampshire when I was up there on a political campaign a good long while ago, but we are delighted to have him here today.

Mrs. Morrison, we will be glad to hear you first.

PANEL 1—MEDICARE BENEFICIARY VICTIMS: CONSISTING OF DOROTHY MORRISON, CORAL GABLES, FL; ALEXANDER BOOKSTAVER, MIAMI BEACH, FL; AND EARL BOURDON, CLAREMONT, NH

STATEMENT OF DOROTHY MORRISON

Mrs. MORRISON. Thank you.

Congressman Pepper, good morning.

My name is Dorothy Morrison, and I have come from Coral Gables to tell you about my family's experiences with delayed Medicare payments.

It is with much anger and frustration that I tell you my story today. I have shared it with U.S. Senators Lawton Chiles and Paula Hawkins, my State senator, Jack Gordon, and countless persons at Blue Cross/Blue Shield and the Health Care Financing Administration. In fact, I wouldn't be surprised if several of your panelists have not already heard of the famous Mrs. Morrison.

I took my complaints to a talk show on WNWS radio, where Jeff Hanson from Medicare and Didi Cobb from Blue Cross and Blue Shield talked about delayed Medicare payments. They said they would get back to me but never did. The point is, I am not the type to sit back. I think this is a situation that adds up to discrimination against Medicare beneficiaries, and I have been fighting back with as much determination as I can muster.

My husband, who is present today, is 77 years old and has been ill with congestive heart failure since 1978. Each month he must go through a battery of blood tests that costs $109. Medicare pays that charge, and for that I am grateful.

However, Medicare has not yet paid claims from April 28, May 27, or June 23. This adds up to $472, which is a lot of money to us. We live on my husband's Social Security check and our savings. When we try to get payment on these Medicare claims, all we get is excuses and no action.

I know that it requires a reasonable time to handle the claims received by the Medicare office, but 3 months is just too long.

In recent months, we have had a devil of a time trying to get Medicare and Blue Cross/Blue Shield to pay his claims. I have heard every excuse."The computers are down." "The claims were never received." "We are training new people." "We will have the situation under control in October."

I worked many years as a bookkeeper and know how to keep good records. I have carefully logged the number of calls I have made and the number of letters I have written. I have resubmitted claims as often as four times. I do not mind doing these things, but my extra effort still does not bring me the result I want, which is to have the claims paid in a reasonable period of time. And just as a memorandum, I have all that data with me, and I would like to submit it into the record when I am through with my testimony.

Mr. PEPPER. We would be happy to receive it.

Mrs. MORRISON. All right.

[See appendix for additional material submitted for the record by Mrs. Morrison.]

According to the Medicare law, all persons who pay the monthly premium of $15.50 from their Social Security are entitled to the benefits prescribed by the law. The Government will not let us delay payment on our monthly part B premium by 3 months. The IRS will not let us wait 3 months to pay our income tax. Yet, we are expected to somehow scrape by and wait an entire quarter year to receive payment on our Medicare claims.

It is unfair and cruel to all Medicare recipients to get this type of treatment. The aggravation one must put up with is unjust and demeaning.

Every time I have to call the Medicare office, I get angry because it is just wasted time on my part, and I get no results.

The one bright spot has been Mr. Jeff Rust, a supervisor at Medicare, who has gone out of his way to assist me since 1985. He personally advised me when my claims had been received and was always willing to talk with me.

There are many people in the same situation with delayed Medicare claims. Some are in far worse financial straits than we are. I feel for all of them. Getting their claims settled is as important to them as it is to us.

All we are asking for is what we feel we are rightly entitled to and not a lot of excuses.

I commend Congressman Pepper for calling this hearing. It would please me no end to hear today that corrective measures will be taken and that Florida's Medicare beneficiaries will again enjoy payment of their claims within a reasonable time.

Thank you.

Mr. PEPPER. Thank you very much, Mrs. Morrison. We will defer questions, if we may, until we have heard all the members of the panel.

Mrs. MORRISON. All right.

Mr. PEPPER. Thank you for your excellent statement.

Mrs. MORRISON. Thank you.

Mr. PEPPER. Our next panelist is Mr. Alexander Bookstaver of Miami Beach.

STATEMENT OF ALEXANDER BOOKSTAVER,

Mr. BOOKSTAVER. Good morning, Senator Pepper and Congressman Fascell.

My name is Alexander Bookstaver, and I am a 75-year-old resident of Miami Beach, FL. My wife and I are Medicare beneficiaries and are currently owned approximately $500 from that program.

I did not come here to bellyache. I did not come to blame Blue Cross or the Health Care Financing Administration or anyone else. I just want to state emphatically that there is a serious problem, and, regardless of whose fault it is, it ought to be fixed at once.

I used to work in Washington, DC, as investment director at the AFL-CIO. I know that when you have problems in a business, you look for remedies. Medicare is a business of sorts. It ought to get its act together.

My wife and I are living comfortably on Social Security, a few dollars in savings, and my small pension. Still, it is unusual to be owed $200 for a claim I filed under Medicare in April.

Friends of mine, who have incomes smaller than ours, are having to choose between buying medicine and drugs and buying food and things like that.

I can understand that it takes a certain period of time to process Medicare claims. But honestly, go from an average 3-week turnaround to a 3-month-or-more turnaround is beyond my comprehension.

I think it is time for justice to be shown to seniors. If the Government has been withholding our payments for a certain period of time, why can't they pay us the interest that the money has earned?

I had a friend of mine recently remark that he thought Blue Cross was probably investing his Medicare money in money market funds. Well, he was joking, of course, but we are starting to wonder what has happened to this money which is rightfully ours.

I also resent some of the runaround I have been getting when I call to find out what became of my Medicare claims. I have heard it all: my bill has been referred to some committee for review; they are training a new staff and will have the situation under control soon. This is difficult to understand and possibly is an insult to my intelligence.

This whole affair left me frustrated, so much so that I finally wrote Congressman Pepper a letter advising him to take some action. I am pleased to see that he has called for action with this hearing.

I commend him and the other Florida Congressmen, and I hope that they will follow through with corrective action that will eliminate the horrid delay of Medicare payments once and for all.

Mr. PEPPER. Thank you again, Mr. Bookstaver, for your excellent statement.

We will next hear from Mr. Earl Bourdon of Claremont, NH, a board member of the National Council of Senior Citizens.

Most of you know that the National Council of Senior Citizens is having its national convention here. I have the honor to appear before them at their banquet this evening, but we are delighted that they are here, and we are pleased to have Mr. Bourdon here this morning.

Mr. Bourdon, will you proceed?

STATEMENT OF EARL BOURDON, CLAREMONT, NH

Mr. BOURDON. Thank you, Mr. Chairman and members of the committee.

My name is Earl Bourdon. I am, as the chairman said, from Claremont, NH. I am here to attend the convention of the National Council of Senior Citizens, and I am very happy to be here this morning to testify on what I think is a very important bill, and I am here not just because I was asked to be, but because I think Medicare is very important.

I am here because I think it is the responsibility of the National Council of Senior Citizens to be here, for it was the fight to get Medicare in the first place that gave birth to the National Council of Senior Citizens. We are here at this convention to celebrate our 25th anniversary. However, we feel it is unfortunate that while we

are celebrating the 25th anniversary of an organization that was born of the fight to have Medicare we have to come here to help save Medicare's credibility at the time when health care is so important to so many people.

As you well know, Mr. Chairman, health care is foremost on the minds of senior citizens and almost every other age group in American society today. And we were pleased to learn that you had scheduled this hearing while the National Council of Senior Citizens was is in Miami Beach.

We applaud the tireless work that your committee and you, particularly, do for us; and the National Council of Senior Citizens, our delegates, and our friends at the Fontainebleau eagerly look forward to your visit with us there tonight.

During the past few days, I have had the opportunity to talk with seniors from all over this country. One of the many things we have been discussing, as you might guess, is Medicare, our high medical costs, and budget cuts.

I understand that the insurers who pay the bills for Medicare have been advised to take their time making payments in order to save the Government some money. I feel it is not fair, and it is hurting us and hurting everybody else, too, and I asked the people at the convention about their experiences.

Senior citizens from all over this country, from New Hampshire, Tennessee, Illinois, Florida, Washington State, and California, all had stories to tell. They told me, yes, there are many instances of Medicare paying bills very slowly.

It does not matter if it is a reimbursement to a Medicare beneficiary, a hospital, a doctor, an ambulance driver, or a medical equipment supplier, the story is the same. Medicare contractors are taking longer and longer to pay the people who have given us a medical service or to reimburse us after we have paid our bills.

I think the matter, parenthetically, is a little worse in northern New England than the national average; and I think that is a disaster, for in northern New England the administration of health care services in the Nation has changed the nature of the area where the contractor provides his Medicare payments. Previously, it was Blue Cross/Blue Shield of New Hampshire that was the Medicare provider for New Hampshire residents; and they have changed that and the area now is Maine, New Hampshire, and Vermont; and it is administered not by anybody in Maine, New Hampshire, or Vermont, but by Massachusetts Blue Cross/Blue Shield; and the payments are even more delayed than this.

Within the last month, I had a resident in a National Council of Senior Citizens Low Income Housing Project come to me with a letter that he received from Blue Cross/Blue Shield with a breakdown of the bills that had been paid and what bills had been submitted, and they said, "Your check is enclosed," and there was no check in the letter.

So, I called the Blue Cross/Blue Shield Massachusetts provider, explained what the letter was, and they took some time and they looked it up, and they very honestly told me, "Yes, that's true. We sent that letter out without a check, and the same day we sent that letter out without a check, we sent a hundred other letters out without checks, too." It was a common error that affected a hun-

dred people all over northern New England; and it ought to stop, not only because it is unjust to senior citizens, but that kind of thing for doctors, for any kind of health care providers, and for senior citizens, is a thing that is going to destroy the beauty and the wonder of Medicare because it will destroy it credibility; and you ought not to permit this to happen.

This is a serious problem that cannot be ignored. Why are we concerned? Well, it is not a case of "Too bad, the doctor didn't get paid." It is a matter of "We didn't get paid," or "The doctor won't take Medicare assignment anymore," or " The ambulance company won't have anything to do with Medicare anymore." In some cases, seniors are even hounded by bill collectors. One Florida National Council of Senior Citizens member told me, "This is a war of nerves against the elderly."

Some of our Florida members told me that doctors get so tired of waiting months for Medicare payments that they send bills to collection agencies. Well, bill collectors comes to seniors and scare them to death.

Even health maintenance organizations have been billing Medicare beneficiaries. The HMO's claim that the Government holds back payment so it can earn the interest on the money.

Many doctors in Florida and elsewhere demand cash payment up front because they say they cannot count on Medicare to pay. Doctors in other parts of the country tell their elderly patients that they, the doctors, have to borrow money because Medicare's payments are too slow; and it is going to encourage all over the country the reluctance of doctors to take Medicare assignment. And we ought to stop that, too.

All of this is very upsetting to the National Council of Senior Citizens and to its members. That is why I have brought this message from my fellow senior citizens at the National Council of Senior Citizens Convention, Mr. Chairman.

As part of my role in the National Council of Senior Citizens Convention, I was cochairman of a workshop on health care. We talked about Medicare, long-term health care, and catastrophic coverage, among other important issues. We adopted a set of resolutions which will be presented to the delegates tomorrow morning. One of the resolutions is entitled "A Message to the Health Care Care Financing Administration," and, boy, do they need a message.

It is a four-part message we believe is necessary because HCFA is overly influenced by fiscal objectives. In this resolution, we ask that the Health Care Financing Administration be more responsive to the needs of the elderly through such means as prohibiting Medicare contractors delaying payments of claims to providers or patients and to pay interest on claims not paid within a reasonable amount of time.

These resolutions, Mr. Chairman, once they are adopted by our convention, will be made available to your committee.

Mr. Pepper and members of the committee, we have suffered enough abuse from budget "savings" to Medicare. Out-of-pocket expenses continue to grow. The Government saves money on DRG's, our part A deductible rises astronomically, and we are sent home from hospitals before we are ready to leave. And now we are expected to take another hit. Well, we cannot, and we appeal to you,

Mr. Chairman and members of the committee, for your help to stop it. Stop it now so that we can get on from this argument about Medicare and decent payments and quick payments to the argument we ought to be having anyway. We ought to be moving from where we are to the adoption of a comprehensive national health insurance plan for all Americans.

Thank you.

Mr. PEPPER. Than you very much. Very well said.

We want to thank, through you, the National Council of Senior Citizens for their proposed resolution of which you spoke. That will be very helpful to us in trying to correct this situation in Washington.

I wrote a letter May 1 of this year to the Secretary of Health and Human Services, the Honorable Otis Bowen, and I said,

> Your assistance in a matter of importance to America's 31 million Medicare recipients would be appreciated. I am concerned that recent actions by the Health Care Financing Administration to reduce expenditures may be counterproductive. Under the Gramm-Rudman-Hollings Resolution Reduction Act, the Congress exempted Medicare benefits from the automatic 4.3-percent across-the-board sequestration. Reductions in Medicare payments were limited to 1 percent in fiscal year 1986.

Administrative funding for the Medicare programs was not protected, as I said a moment ago. Then I said,

> One of the methods chosen by HCFA to save 4.3 percent in expenditures by Medicare carriers and fiscal intermediaries was to order a slowdown in payments to the providers of services. Furthermore, actual payments for trained processing staff have been reduced.

And I went on to point out the emerging of this problem that their policies were bringing about, and so, without objection, I would like my letter to appear at this point in the record.

[Letter of Mr. Pepper follows:]

CLAUDE PEPPER, FLORIDA
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U.S. House of Representatives

SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
377 HOUSE OFFICE BUILDING ANNEX 2
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May 1, 1986

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ASSISTANT STAFF DIRECTOR

(202) 226-3483

Dear Secretary Bowen:

Your assistance with a matter of importance to America's 31 million Medicare recipients would be appreciated.

I am concerned that recent actions by the Health Care Financing Administration (HCFA) to reduce expenditures may be counter-productive.

Under the Gramm-Rudman-Hollings deficit reduction act, the Congress exempted Medicare benefits from the automatic 4.3 percent across-the-board sequestration. Reductions in Medicare payments were limited to 1 percent in fiscal year 1986. Administrative funding for the Medicare program was not protected under the Act.

One of the methods chosen by HCFA to save 4.3 percent in expenditures by Medicare carriers and fiscal intermediaries was to order a slowdown in payments to providers of services. Furthermore, actual payments for claims processing have been reduced.

The result of these efforts may be that many Medicare contractors will run out of HCFA money to process claims in advance of the end of the fiscal year. In addition, many providers of services will be damaged by these slower and later payments.

I anticipate that these actions will not only cause financial hardship but also an exodus of providers from Medicare assignment. Legitimate claims will still have to be paid, but the damage to Medicare from these policies will be hard to overcome.

Millions of elderly beneficiaries may be forced to pay bills directly and many will suffer as a result of the delays in paying their claims. I am well aware of the difficult choices you face in making the necessary Medicare reductions. Nevertheless, I urge you to use contingency funds to restore the payment cycle and policies of Medicare contractors. I am certain that the contractors and provider organizations will work with you to identify legitimate areas where administrative savings could be made. I also want to assure you that I and my staff also will be pleased to work with you to achieve these cost reductions in a manner which will cause the least harm to beneficiaries and providers.

Thank you very much in advance for your consideration.

With kindest regards, and

Very sincerely,

Claude Pepper
Chairman
Subcommittee on Health
and Long-Term Care
House Select Committee on Aging

Honorable Otis Bowen
Secretary
Department of Health and Human Services
Washington, D.C. 20515

CP:kqc

Mr. PEPPER. We thank each one of you very warmly for your excellent statements that you have made.

The other day I was talking to the head of the Legal Services Department on the beach, and then later in Miami; and they told me that one of the great disturbances to the elderly people is the demands upon them that they pay their bills when they are unable to do so. They are very sensitive about paying their bills promptly. They are frightened if they do not pay their bills. They think they are going to be sued or brought into some other judicial proceeding, and they are frightened about it. It upsets them.

Most of the elderly people are living on limited incomes, fixed incomes. They do not have too much money. So this today is pointing out the necessity for trying to take meaningful action in the Congress, that this money should be paid to them. They are not the kind of people from whom you should take money and lend it out at interest in order to add to the capital.

If you want to get money from somebody, get it from somebody that has the money that can lend it to you. The elderly are not in a position to make those loans to the Government of the United States.

Would you like to ask a question, Mr. Fascell?

Mr. FASCELL. No, Mr. Chairman. I would like to add my voice to the excellent statements you have made. You have succinctly and with great clarity pointed out what the problem is. It just takes too long to get reimbursed; there is too much paper work; and it costs too much. We have to do something about protecting administrative funding and seeing about getting the cash money up front for the processors so that they can improve their administrative work.

I want to thank all of you for participating.

Mr. PEPPER. Thank you, Mr. Fascell.

Mr. Bilirakis.

Mr. BILIRAKIS. I have no questions, sir.

I, too, would like to thank the three members of the first panel.

Mr. PEPPER. Thank you very much. Thank you for your excellent contributions.

Now, we will have panel No. 2: "Medicare Provider Victims."

Will you please come up to the witness table? Take your seat at the witness table, please.

Will the staff show the witnesses to their places, please?

The first of the witnesses on the "Medicare Provider's Victims" panel is Mrs. Olga Davis, business manager for a Miami area physicians group.

The next is Mrs. Susanne Justice, Florida Association for Home Care.

The next is Mr. Mario Espino, president of American Medical Rentals of Miami.

And next is Dr. Mark Feldman, private practice physician of Miami Beach.

And the next is Mr. David Nesslein, president, Mederi Home Health Care of Miami.

First will be Mrs. Olga Davis, business manager for a Miami area physicians' group.

Mrs. Davis.

PANEL 2—MEDICARE PROVIDER VICTIMS: CONSISTING OF OLGA M. DAVIS, BUSINESS MANAGER FOR MIAMI AREA PHYSICIAN GROUPS: SUSANNE JUSTICE, R.N., ADMINISTRATOR, MEDIHEALTH OF FLORIDA, INC., AND PAST PRESIDENT OF FLORIDA ASSOCIATION OF HOME HEALTH AGENCIES, MIAMI, FL: MARIO A. ESPINO, JR., PRESIDENT, AMERICAN MEDICAL RENTALS, INC., MIAMI, FL: DR. MARK FELDMAN, PRIVATE PRACTICE PHYSICIAN, MIAMI, FL, AND DAVID NESSLEIN, SECRETARY, MERDI, INC., MIAMI, FL

STATEMENT OF OLGA M. DAVIS

Ms. DAVIS. My name is Olga Davis, and I work full time as administrator-business manager for a group of three Miami internists. In addition, I have a medical management company that presently handles six Miami physicians' practices in different parts of the Dade County area, all with different specialties.

Therefore, I feel qualified to be here to comment on the Medicare situation which is affecting physicians and patients alike. I hope that as a result of these hearings today and the help of our concerned lawmakers, a solution to the Medicare problem is promptly obtained.

About the issue that prompted the hearing, the slowdown in the processing of Medicare claims, I can safely state that it has greatly affected physicians and patients and that if it is allowed to continue, it will have very bad consequences.

As I mentioned, my primary concern, needless to say, are the doctors. The doctors that have been put through a lot by Medicare throughout the years and who are now facing serious financial problems, because of this slowdown in the payment of claims.

As you all know, in 1983, a physician's fee freeze went into effect, as a mechanism for containing health care costs. In July 1985, the Government promised the fees would be unfrozen. This did not happen. Now, in 1986, the physicians' rates are still the same, but they were also cut by 1 percent. In most doctors' eyes, Medicare has gone back on its word. It did not keep its promises, and the confidence of the doctors in the Medicare Program is getting very, very low.

Also, it is not in my speech, but I want to mention it. On the delay of Medicare claims, doctors were waiting 5 and 6 months to be paid. Then all of a sudden when the requisition from Blue Cross/Blue Shield that doctors became Medicare participants of the "accept assignment program," all of a sudden the payments started coming in.

Prior to that, my physicians had been waiting 4 and 5 months for payments, and I will give you examples. A cardiologist in Hialeah was owed $29,569, some of those claims going back to December 1985. A gastroenterologist located at Mercy Hospital was owed $13,650. My primary employer, which is a group of three physicians, was owed $21,491, many of those claims for December and January. With figures like this, my primary employers did have to take a loan, which we are presently paying at a pretty high interest rate.

On the other complaints, since I was given the opportunity to talk about the Medicare Program, I also want to mention the fact

that, before—this is very little compared to the big problems—the Medicare forms were free. Now, doctors have to buy them.

Also, effective October 1985, the doctors, I presume all the providers, were no longer allowed a toll-free number. Now, if we want to inquire on a claim, we have to call and pay for the call.

When you call Blue Cross/Blue Shield, you are put on hold for a long time, and then, of course, this is another way to curtail inquiries from the providers as to what is happening to their claims.

In addition, Medicare will very rarely, but on occasions, send a double payment. They will notify the physician that they owe the money. This money they have to return immediately, or it will be taken from future claims. So, Medicare does not wait for its money, but yet Medicare certainly likes for the physicians and the providers to wait for theirs.

I could go on, and on, saying all the things that have been happening within the past 4 to 5 years with this final stroke of the delay in Medicare payments.

Thank you very much. My apologies because my speech had nothing to do with what was written.

[The prepared statement of Ms. Davis follows:]

STATEMENT OF OLGA M. DAVIS, MIAMI, FLORIDA

Hello. My name is Olga Davis and I work full-time as administrator-business manager for a group of three Miami internists. I also work part-time for 5 other physicians around the area, all of whom are in different disciplines. I feel qualified to be here as a witness today because I have seen how our older patients and the doctors themselves have been hurt by delays in Medicare payment. I hope that, in the short term, payments can be made in a much more timely fashion to patients and providers alike. I am afraid, though, that this will not solve a long-term problem -- doctors' faith in the Medicare program has been shaken. Every single physician I work for has decided not to accept assignment for Medicare. They would like to help elderly patients on Medicare but sometimes it's not worth the hassle.

The worst thing about these tardy Medicare reimbursements is that they hurt everybody. I pride myself on being a good manager and an organized businessperson. I've found it a rude awakening to be deluged by complaints, from patients at all my doctors' practices, that payments are tardy. This new procedure has made my life very complicated.

As I mentioned, patients are feeling the financial strain of delayed payment, too. Some of them are owed hundreds of dollars, and for persons living on fixed income, the situation is stressful indeed. I know many persons who are reluctant to go to the doctor's office at all now -- they know they might not see payment from Medicare for months.

My primary concern, as you might guess, lies with the people I work for, the doctors. Doctors have been through a lot with Medicare through the years. I think this delay in reimbursement represents yet another swipe at doctors by the Federal government.

I just want to take a few minutes to describe some of the factors leading to physicians' disenchantment with the Medicare program.

In July 1983, a physicians' fee freeze went into effect, as a mechanism for containing health care costs. In July 1985, the government promised the fees would be unfrozen. This didn't happen. Now, in 1986, the physicians' rates still have not been allowed to rise -- in fact, they were cut 1%. In most doctors' eyes, Medicare has gone back on its word. It didn't keep its promises. I think confidence in the program will be difficult, or impossible, to restore.

The things I have observed are hard to believe. The doctors I work for, in one four-month period, were owed $29,569, $13,650, $21,491, and $13,165 each. With figures like this, I'm sure you can understand why my principal employer, Keyes-Spitzer-Bustin, has had to take out loans -- and business loans have a high interest level at present -- in order to cover the operating expense of this association of three doctors.

Then there are some lesser complaints doctors have with the Medicare program. The Medicare forms used to be provided free of charge, for example, and now physicians' offices must pay for them. There was a toll-free number for information on claims, but Medicare has eliminated that. (That again has hurt both providers and Medicare patients.) Then there is the gross indignity with which Medicare seems to treat doctors. One physician I know was owed $2,000 from Medicare because of tardy processing of claims. He had received an extra $200 from Medicare at one time due to double billing. Medicare told him he'd have to pay back that $200 before one penny of the $2,000 they owed him could be paid. I see that as symbolic of the attitude of Medicare toward physicians. I'm sure I could go on and on with examples -- it's difficult for me to stay within the time limit, I feel so strongly about this issue.

To summarize, I find it hard to believe older Americans, many of whom have limited incomes, and physicians, who really want to be of aid to Medicare patients, are being denied prompt payment on their claims. When I think of the doctors' situation with Medicare over the past few years, it strikes me as "death by 1,000 cuts." Medicare has subjected doctors to many, many small punishments. They're declining to accept assignment. Some are moving to the suburbs, where the communities are generally younger -- fewer Medicare recipients. I am pleased you have called this hearing, Congressman Pepper, to correct the problem of delayed payment. I think the problem is much deeper, however, and I hope that in future sessions you will also look at the plight of physicians under Medicare. Thank you.

Mr. PEPPER. Thank you very much, Mrs. Davis, for your excellent statement.

Next, we will have Mrs. Susanne Justice, Florida Association for Home Care.

STATEMENT OF SUSANNE JUSTICE

Ms. JUSTICE. Thank you.

Mr. Chairman and members of the committee, I will briefly synopsize my written testimony, which I would like to present for inclusion in the record.

My name is Susanne Justice. I am the administrator of Medi-Health, here in Miami and immediate past president of Florida Association of Home Health Agencies, and a former board member of the National Association of Home Care.

On behalf of these two associations and home health providers, both here in Florida and across the Nation, would like to commend you for holding this important hearing and bring the Medicare claims delay issues into the public eye.

HCFA has testified before the Ways and Means Health Subcommittee that in order to live within a reduced contractor budget for fiscal year 1986, "An increase in contractor claims payment time has been necessitated." This "temporary inconvenience," HCFA states, purportedly will save the Medicare trust fund $132 million in interest.

Without question, HCFA has been successful in achieving its objectives, as numerous delays of well over 120 days are being reported by home health agencies around the Nation.

A recent survey conducted by the Louisiana Association of Home Care found that 18 percent of those responding had not received Medicare payments in over 120 days, and two agencies each were owed over $300,000.

Some Florida providers have received denial notices in April 1986, for services rendered and claims submitted in August 1985. Similar delays have been documented in Pennsylvania, Minnesota, Wyoming, Montana, and Oklahoma.

As these reports indicate, the situation is out of hand.

In an effort to get uniform national data on the extent of this problem, the national association has completed a nationwide survey on the home health claims delay problem. The results clearly confirm the experiences reported above.

With 380 agencies across the country responding, 88 percent report that during the past 6 to 9 months, the average lag time between the date claims are submitted and the date payment or denial is received is well in excess of a month. In region IV 90 percent confirm this finding: 49 percent report that since January, they have noticed that their intermediary or carrier is less responsive to inquiries about delayed payments, policy changes, or manual changes.

Delays in Medicare claims payments effect agency operations in the following manners: 59 percent are forced to incur additional administration costs; 46 percent are unable to pay bills on time; 43 percent are forced to borrow money; 27 percent are unable to meet their payrolls; 15 percent are forced to reduce the provision of indi-

gent care; and 10 percent are forced to reduce services to beneficiaries.

It is not only naive but dangerous to assume that by encouraging slowdowns in claims processing, HCFA is saving money with only minor inconvenience and no other significant costs being extracted.

Delays inevitably elicit the responses described above, and providers must also increase short-term borrowing at substantial interest costs, borne in part by the Medicare Program.

Claims payment delays increase the number of duplicate bills submitted, producing an seven greater workload for an already overloaded system. Increased provider and beneficiary inquiries will also raise program administrative costs and exacerbate the backlog problem.

Here in Florida, our problem with claims delays is of a different nature. According to Aetna, 68 percent of the home health agencies in Florida served by them are on P.I.P., which is periodic interim payments. Therefore, we do not depend on concurrent claims processing for our reimbursement. We are paid the same amount every 2 weeks, based on the prior quarter's financial and statistical reports. Aetna feels they have an excellent claims payment record with the majority of claims paid promptly.

For P.I.P. providers, the majority is not what is important. It is the minority of claims that have delayed payments that are devastating to these providers.

When our cost report is finalized by Aetna up to 1 year after your fiscal year end, any Medicare claims that have not yet been paid are then reclassified as private visits instead of Medicare visits. The provider must then pay back that money within 30 days, and when the claims are finally paid, they must ask for a reopening of that cost report, a process that can take 1 to 2 years and which will incur additional accounting fees.

The providers are, therefore, penalized twice. We provide the services to Medicare patients and bill for same. Aetna delays the claim payments, so we must pay the money back that we have legitimately spent on care, and then we must request the cost report reopening and wait for reimbursement of that money up to 2 years.

Let me give you an example that will explain the issue more graphically. I personally have experienced this problem with my last two cost reports.

Services were rendered by my agency to a Medicare patient in March and April of 1984. The April claim was paid, but despite repeated duplicate or tracer bills and inquiries, the March bill was never paid.

When my fiscal year cost report was audited in 1985, they reclassified those Medicare visits into private visits, and I had to pay that money back. There were two other delayed payment claims involved as well.

To this day, over 2 years later, that one claim is still not paid. The other two claims have been processed, but my cost report will not be reopened until all three of the claims are cleared. Therefore, one 1984 claim has delayed my reimbursement all this time.

The cash-flow problems caused by all these delays are having a more significant adverse effect in the home health area than for any other type of health provider. This is true for four reasons:

(1) HCFA's Intermediary Bill Processing Time Report shows that the time taken to process bills for home health agencies exceeded that of inpatient, outpatient, and skilled nursing facilities.

(2) Medicare accounts for approximately two-thirds of home health agencies' revenues, many relying 100 percent on the program.

(3) Home health agencies tend to be smaller businesses than other health care providers, making it much more difficult to borrow money, and

(4) HCFA has vastly increased administrative and other costs of agencies over the past year while reducing total reimbursement rates. Hospital DRG's have also resulted in patients needing higher acuity, more expensive home care services, while HCFA continues to use fiscal year 1983 data in computing these cost limits.

Besides supporting increased appropriations for claims processing functions and improving P.I.P., devising a mechanism to insure that claims are logged in when they are received, we also make the following recommendations for addressing the Medicare claims delay problems:

First, require that FI's process and pay claims within a reasonable period of time, after which they should be required to pay interest;

Second, conduct a demonstration project on prior authorization of claims where coverage determinations are made before services are rendered. At a minimum, create a system for expedited review;

Third, change the Contractor Performance Evaluation Program timeliness standard to account for time taken to pay a claim in addition to mere work on hand, and make it a critical element; and

Fourth, make it easier for agencies to receive periodic interim payments and accelerated payments.

This concludes my testimony. Thank you for giving me the opportunity to appear today.

[The prepared statement of Ms. Justice follows:]

PREPARED STATEMENT OF SUSANNE JUSTICE, R.N.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

MY NAME IS SUSANNE JUSTICE. I AM THE ADMINISTRATOR OF MEDI-HEALTH IN MIAMI, FLORIDA, IMMEDIATE PAST PRESIDENT OF THE FLORIDA ASSOCIATION OF HOME HEALTH AGENCIES, (FAHHA) A FORMER MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL ASSOCIATION FOR HOME CARE, (NAHC) AND CURRENT CHAIRPERSON OF FLORIDA'S INTERMEDIARY LIAISON COMMITTEE.

ON BEHALF OF HOME HEALTH PROVIDERS BOTH HERE IN FLORIDA AND ACROSS THE NATION, I WOULD LIKE TO COMMEND YOU FOR HOLDING THIS IMPORTANT HEARING AND BRINGING THE MEDICARE CLAIMS DELAY ISSUES INTO THE PUBLIC EYE. I AM VERY PLEASED TO HAVE THIS OPPORTUNITY TO PRESENT MY VIEWS ON THIS PROBLEM AND WHAT IT MEANS FROM A HOME CARE PROSPECTIVE.

HCFA HAS TESTIFIED BEFORE THE WAYS AND MEANS HEALTH SUBCOMMITTEE THAT, IN ORDER TO LIVE WITHIN A REDUCED CONTRACTOR BUDGET FOR FY 1986, "AN INCREASE IN CONTRACTOR CLAIMS PAYMENT TIME HAS BEEN NECESSITATED." THIS "TEMPORARY INCONVENIENCE," HCFA STATES, PURPORTEDLY WILL SAVE THE MEDICARE TRUST FUND $132 MILLION IN INTEREST.

WITHOUT QUESTION, HCFA HAS BEEN SUCCESSFUL IN ACHIEVING ITS OBJECTIVES, AS NUMEROUS DELAYS OF WELL OVER 120 DAYS ARE BEING REPORTED BY HHA'S AROUND THE NATION. A RECENT SURVEY CONDUCTED BY THE LOUISIANA ASSOCIATION OF HOME HEALTH AGENCIES FOUND THAT 18 PERCENT OF THOSE RESPONDING HAD NOT RECEIVED MEDICARE PAYMENTS IN OVER 120 DAYS, AND 2 AGENCIES WERE EACH OWED OVER $300,000. SOME FLORIDA PROVIDERS HAVE RECEIVED DENIAL NOTICES IN APRIL 1986 FOR SERVICES RENDERED AND CLAIMS SUBMITTED IN AUGUST 1985. SIMILAR DELAYS HAVE BEEN DOCUMENTED IN PENNSYLVANIA, MINNESOTA, WYOMING, MONTANA AND OKLAHOMA. DURING THE MARCH NAHC LEGISLATIVE AND REGULATORY CONFERENCE, THE FOLLOWING REPORTS ON SLOWDOWNS WERE RECEIVED FROM SOME PROVIDERS:

- CALIFORNIA - BACKED UP FROM JULY 1985
- ILLINOIS - 3 TO 4 MONTHS BEHIND; MANY CLAIMS "LOST"
- NEBRASKA - 3 TO 6 MONTHS BEHIND
- MICHIGAN - PROCESSING NOVEMBER 1985 BILLS IN MARCH 1986
- GEORGIA - IN EXCESS OF 2 MONTHS BEHIND
- ARIZONA - 3 MONTHS BEHIND
- NEW MEXICO - 2 TO 3 MONTHS BEHIND
- MISSOURI - 3 TO 5 MONTH DELAYS
- DELAWARE - 2 TO 3 MONTHS BEHIND

- FLORIDA - 4 TO 5 MONTH DELAYS
- MISSISSIPPI - 3 TO 4 MONTHS BEHIND
- TENNESSEE - 3 TO 6 MONTHS BEHIND
- INDIANA - DELAYS EXTENSIVELY BEYOND 2 MONTHS
- NORTH DAKOTA - 4 TO 6 MONTH DELAYS, WITH TRIPLE REQUESTS FOR THE SAME INFORMATION
- OREGON - 87 CLAIMS WITH 3 OR MORE MONTH DELAYS

AS THESE REPORTS INDICATE, THE SITUATION IS ALREADY OUT OF HAND. IN AN EFFORT TO GET UNIFORM NATIONAL DATA ON THE EXTENT OF THIS PROBLEM, NAHC HAS COMPLETED A NATIONWIDE SURVEY ON THE HHA CLAIMS PAYMENT DELAY PROBLEM. THE RESULTS CLEARLY CONFIRM THE EXPERIENCES REPORTED ABOVE. WITH 380 AGENCIES ACROSS THE COUNTRY RESPONDING:

- 88 PERCENT REPORT THAT, DURING THE PAST 6 TO 9 MONTHS, THE AVERAGE LAG TIME BETWEEN THE DATE CLAIMS ARE SUBMITTED AND THE DATE PAYMENT OR DENIAL IS RECEIVED IS MORE THAN ONE MONTH. IN REGION IV 90% CONFIRM THIS FINDING.

- 77 PERCENT REPORT THAT, SINCE SEPTEMBER 1, 1985, THEY HAVE NOTICED AN APPRECIABLE DELAY IN THE TIME IT TAKES MEDICARE TO PAY A CLAIM.

- 49% REPORT THAT, SINCE JANUARY THEY HAVE NOTICED THAT THEIR INTERMEDIARY OR CARRIER IS LESS RESPONSIVE TO INQUIRIES ABOUT DELAYED PAYMENTS, POLICY CHANGES OR MANUAL CHANGES.

- DELAYS IN MEDICARE CLAIM PAYMENTS EFFECT AGENCIES OPERATIONS IN THE FOLLOWING MANNER;
  - 59% ARE FORCED TO INCUR ADDITIONAL ADMINISTRATIVE COSTS
  - 46% ARE UNABLE TO PAY BILLS ON TIME
  - 43% ARE FORCED TO BORROW MONEY
  - 27% ARE UNABLE TO MEET THEIR PAYROLL
  - 15% ARE FORCED TO REDUCE THE PROVISION OF INDIGENT CARE.
  - 10% ARE FORCED TO REDUCE SERVICES TO BENEFICIARYS.

IT IS NOT ONLY NAIVE, BUT DANGEROUS TO ASSUME THAT BY ENCOURAGING SLOWDOWNS IN CLAIMS PROCESSING, HCFA IS "SAVING" MONEY WITH ONLY MINOR INCONVENIENCE AND NO OTHER SIGNIFICANT COSTS BEING EXTRACTED. DELAYS INEVITABLY ELICIT THE RESPONSES DESCRIBED ABOVE, AND PROVIDERS MUST ALSO INCREASE SHORT-TERM BORROWING AT SUBSTANTIAL INTEREST COSTS, BORNE IN PART BY THE MEDICARE PROGRAM. THUS, INTEREST COSTS ARE SIMPLY SHIFTED UNFAIRLY ONTO THE SHOULDERS OF HHA'S AND OTHER PROVIDERS, WHO MUST PAY WHAT, IN EFFECT, ARE INCREASED TAXES.

NAHC MUST ALSO QUESTION THE SAVINGS ESTIMATES CITED BY HCFA. MEDICARE CONTRACTORS HAVE CONTINUALLY ARGUED TO DEAF EARS THAT ALLOWING DAYS WORK ON HAND (DWOH) TO ESCALATE DOES JUST THE OPPOSITE OF SAVING FEDERAL DOLLARS. THE HEALTH INSURANCE ASSOCIATION OF AMERICA HAS TESTIFIED STATING: "SEVEN OF THE LARGER CONTRACTORS, REPRESENTING 40 PERCENT OF THE PART B CLAIMS, CONDUCTED A STUDY OF THE COST VS. SAVINGS. EXTRAPOLATED FROM THE STUDY, FIGURES SHOW A BACKLOG OF 18 DWOH WILL GENERATE A ONE TIME SAVINGS OF $5.8 MILLION BUT WILL BE OFFSET BY AN ANNUALIZED COST OF $18.2 MILLION. THESE ARE VERY CONSERVATIVE FIGURES, IN THAT ALL AREAS THAT COULD NOT BE QUANTIFIED WERE ELIMINATED. (EMPHASIS IN THE ORIGINAL)." CLAIMS PAYMENT DELAYS INCREASE THE NUMBER OF DUPLICATE BILLS SUBMITTED, PRODUCING AN EVEN GREATER WORKLOAD FOR AN ALREADY OVERLOADED SYSTEM. SINCE THE WORKLOAD IS SIMPLY BUILDING UP MORE AND MORE, ONE CAN ANTICIPATE THAT THE DELAYS DESCRIBED ABOVE WILL ONLY GROW WORSE AS THE YEAR PROGRESSES, UNLESS SOMETHING IS DONE. INCREASED PROVIDER AND BENEFICIARY INQUIRIES WILL ALSO RAISE PROGRAM ADMINISTRATIVE COSTS AND EXACERBATE THE BACKLOG PROBLEM. OTHER REACTIONS TO THE PROBLEM INCLUDE REDUCED SUBMISSION OF ELECTRONIC CLAIMS AND REDUCED ASSIGNMENT RATES.

HERE IN FLORIDA OUR PROBLEM WITH CLAIMS DELAYS IS OF A DIFFERENT NATURE. ACCORDING TO AETNA, 68% OF THE HOME HEALTH AGENCIES IN FLORIDA SERVED BY THEM ARE ON P.I.P. (PERIODIC INTERIUM PAYMENTS). THEREFORE WE DO NOT DEPEND ON CONCURRENT CLAIMS PROCESSING FOR OUR REIMBURSEMENT. WE ARE PAID THE SAME AMOUNT EVERY 2 WEEKS BASED ON THE PRIOR QUARTERS FINANCIAL & STATISTICAL REPORTS. AETNA FEELS THEY HAVE AN EXCELLANT CLAIMS PAYMENT RECORD WITH THE MAJORITY OF CLAIMS PAID PROMPLTY. FOR P.I.P. PROVIDERS THE "MAJORITY" IS NOT WHAT'S IMPORTANT. IT IS THE "MINORITY" OF CLAIMS THAT HAVE DELAYED PAYMENTS THAT ARE DEVASTATING TO P.I.P. PROVIDERS. WHEN OUR COST REPORT IS FINALIZED BY AETNA UP TO A YEAR AFTER OUR F.Y.E., ANY MEDICARE CLAIMS THAT HAVE NOT YET BEEN PAID ARE THEN RECLASSIFIED AS "PRIVATE" VISITS INSTEAD OF MEDICARE VISITS. THE PROVIDER MUST THEN PAY THAT MONEY BACK WITHIN 30 DAYS AND WHEN THE CLAIMS ARE FINALLY PAID, THEY MUST ASK FOR A REOPENING O. THAT COST REPORT, A PROCESS THAT CAN TAKE 1 - 2 YEARS AND WHICH WILL INCUR ADDITIONAL ACCOUNTING FEES. THE PROVIDERS ARE THEREFORE PENALIZED TWICE. WE PROVIDE THE SERVICES TO MEDICARE PATIENTS AND BILL FOR SAME, AETNA DELAYS THE CLAIM PAYMENTS SO WE MUST PAY MONEY BACK THAT WE'VE LEGITIMATLY SPENT ON CARE, AND THEN WE MUST REQUEST THE COST REPORT REOPENING AND WAIT FOR REIMBURSEMENT OF THAT MONEY UP TO 2 YEARS.

LET ME GIVE YOU AN EXAMPLE THAT WILL EXPLAIN THE ISSUE MORE GRAPHICALLY. I PERSONALLY HAVE EXPERIENCED THIS PROBLEM WITH MY LAST 2 COST REPORTS. SERVICES WERE RENDERED BY MY AGENCY TO A MEDICARE PATIENT IN MARCH & APRIL OF 1984. THE APRIL CLAIM WAS PAID BUT DESPITE REPEATED DUPLICATE OR TRACER BILLS AND INQUIRES THE MARCH BILL WAS NEVER PAID.

WHEN MY F.Y.E. 8/31/84 COST REPORT WAS AUDITED IN 1985 THEY RECLASSIFIED THOSE MEDICARE VISITS INTO PRIVATE VISITS AND I HAD TO PAY THAT MONEY BACK. THERE WERE 2 OTHER DELAYED PAYMENT CLAIMS INVOLVED AS WELL. TO THIS DAY, OVER 2 YEARS LATER THAT ONE CLAIM IS STILL NOT PAID. THE OTHER 2 CLAIMS HAVE BEEN PROCESSED BUT MY COST REPORT WILL NOT BE REOPENED UNTIL ALL 3 OF THE CLAIMS ARE CLEARED. THEREFORE ONE 1984 CLAIM HAS RELAYED MY REIMBURSEMENT ALL THIS TIME.

THE SAME THING HAS HAPPENED TO MY F.Y.E. 8/31/85 COST REPORT. THE DESK AUDIT WAS DONE IN MARCH 1986, BUT I RECEIVED CLAIMS PAYMENT LISTINGS FOR THAT FISCAL YEAR IN APRIL OF '86 FOR 58 VISITS. ANOTHER CLAIM FOR 11 VISITS IN AUGUST OF '85 HAS STILL NOT BEEN PROCESSED DESPITE TRACER BILLS. A CASE IN WHICH 44 VISITS HAD BEEN DENIED BUT WHICH WAS REVERSED BY THE ADMINISTRATIVE LAW JUDGE IN MARCH 1986 STILL HAS NOT BEEN PROCESSED BY THE MEDICAL REVIEW SECTION. THEREFORE AETNA'S AUDIT REIMBURSEMENT DEPARTMENT HAS RECLASSIFIED THOSE 113 VISITS AS PRIVATE AND WANTS THE MONEY BACK, ALMOST $6000. THIS IS A TRAVESTY AND A TERRIBLE INJUSTICE TO PROVIDERS.

THE CASH FLOW PROBLEMS CAUSED BY ALL THESE DELAYS ARE HAVING A MORE SIGNIFICANT ADVERSE EFFECT IN THE HOME HEALTH AREA THAN FOR ANY OTHER TYPE OF HEALTH PROVIDERS. THIS IS TRUE FOR FOUR REASONS: (1) CLAIMS PROCESSING DELAYS WERE ALREADY LONGER FOR HHA'S THAN FOR OTHER PROVIDERS. THE HCFA "INTERMEDIARY BILL PROCESSING TIME REPORT" SHOWS THAT THE TIME TAKEN TO PROCESS BILLS FOR HHA'S EXCEEDED THAT OF INPATIENT, OUTPATIENT, AND SKILLED NURSING FACILITIES; (2) HHA'S RELY ON MEDICARE PAYMENTS, ON AVERAGE, MORE THAN OTHER HEALTH CARE PROVIDERS. MEDICARE ACCOUNTS FOR APPROXIMATELY TWO-THIRDS OF HHA'S REVENUES, WITH MANY AGENCIES RELYING 100% ON THE PROGRAM; (3) HHA'S TEND TO BE SMALLER BUSINESSES THAN OTHER HEALTH CARE PROVIDER, MAKING IT MORE DIFFICULT TO BORROW MONEY AGAINST CAPITAL AND (4) HCFA HAS VASTLY INCREASED ADMINISTRATIVE AND OTHER COSTS OF HHA'S OVER THE PAST YEAR WHILE REDUCING TOTAL REIMBURSEMENT RATES. HOSPITAL DRG'S HAVE ALSO RESULTED IN PATIENTS NEEDING HIGHER ACUITY, MORE EXPENSIVE HOME CARE SERVICES, WHILE HCFA CONTINUES TO USE FY 1983 DATA (JUST BEFORE DRG'S WENT INTO EFFECT) COMPUTING COST LIMITS.

WHILE INCREASING APPROPRIATIONS FOR CLAIMS PROCESSING BUDGETS WILL CERTAINLY MAKE IT EASIER FOR CONTRACTORS TO REDUCE DELAYS, NAHC BELIEVES THERE ARE OTHER CAUSES WHICH ALSO SHED LIGHT ON THE NATURE OF THE PROBLEM. HCFA REPORTS THAT THE AVERAGE NATIONAL INTERMEDIARY PROCESSING TIME WAS 22.5 DAYS IN THE FIRST QUARTER OF 1986--HIGHER THAN ANY OTHER PROVIDER GROUP. IF ONE CONSIDERS MAILING TIME, PRINTING AND SORTING TIME, AND SUMMARY CHECK CYCLES, A CLAIM SHOULD TAKE, IN THE WORST CASE, ABOUT 47 DAYS TO PAY--FROM THE TIME IT IS MAILED OUT TO THE TIME IT IS RECEIVED. THIS STILL DOES NOT ACCOUNT FOR THE VOLUMINOUS REPORTS OF DELAYS OF WELL OVER 60 DAYS. WHAT ACCOUNTS FOR THIS DISCREPANCY? THE ANSWER IS THAT CONTRACTORS ARE NOT

ENTERING CLAIMS INTO THE PROCESSING SYSTEM WHEN THEY ARE RECEIVED. NAHC HAS EVIDENCE THAT, RATHER THAN LOGGING IN CLAIMS WITHIN 24 HOURS OF RECEIPT AS REQUIRED BY LAW, CONTRACTORS ARE LETTING THEM SIT ON THE SHELF FOR WEEKS, OR "MOTHBALLING" THE CLAIMS, OR ARE CONVENIENTLY "LOSING" THEM. WE HAVE COMPILED EVIDENCE OF OVER 100 CLAIMS WHICH TOOK WEEKS, AND SOMETIMES MONTHS, TO BE ENTERED INTO THE CLAIMS PROCESSING SYSTEM AFTER THEY HAD BEEN PHYSICALLY RECEIVED BY THE CONTRACTOR.

FOR EXAMPLE, A CLAIM SUBMITTED ON NOVEMBER 27, 1985 WAS NOT LOGGED INTO THE SYSTEM UNTIL JANUARY 7, 1986. ANOTHER CLAIM SUBMITTED DECEMBER 11, 1985 WAS LOGGED IN ON JANUARY 30, 1986. THE LIST GOES ON. THIS REVEALS A SYSTEMATIC EFFORT NOT ONLY TO DELAY THE TIME IT TAKES TO PROCESS A CLAIM, BUT TO LET CLAIMS SIT FOR MANY WEEKS BEFORE THEY ARE EVEN ENTERED INTO THE CLAIMS PROCESSING SYSTEM! SUCH BEHAVIOR IS CLEARLY ILLEGAL AND MUST NOT BE TOLERATED. MECHANISMS SEEMINGLY DO NOT EXIST AT PRESENT TO ENSURE THAT CLAIMS ARE LOGGED IN PROMPTLY. SUCH A MECHANISM MUST BE DEVISED AND ENFORCED.

BESIDES SUPPORTING INCREASED APPROPRIATIONS FOR CLAIMS PROCESSING FUNCTIONS, AND IMPROVING PIP, DEVISING A MECHANISM TO ENSURE THAT CLAIMS ARE LOGGED IN WHEN THEY ARE RECEIVED, NAHC ALSO MAKES THE FOLLOWING RECOMMENDATIONS FOR ADDRESSING THE CLAIMS PAYMENT DELAY PROBLEM:

(1) REQUIRE THAT FI'S PROCESS AND PAY CLAIMS WITHIN A REASONABLE PERIOD OF TIME, AFTER WHICH THEY SHOULD BE REQUIRED TO PAY INTEREST;

(2) CONDUCT A DEMONSTRATION PROJECT ON PRIOR AUTHORIZATION OF CLAIMS, WHERE COVERAGE DETERMINATIONS ARE MADE BEFORE SERVICES ARE RENDERED. AT A MININUM, CREATE A SYSTEM FOR AN EXPEDITED REVIEW OF CLAIMS;

(3) CHANGE THE CONTRACTOR PERFORMANCE EVALUATION PROGRAM (CPEP) "TIMELINESS" STANDARD TO ACCOUNT FOR TIME TAKEN TO PAY A CLAIM IN ADDITION TO MERE DWOH, AND MAKE IT A "CRITICAL ELEMENT"; AND

(4) MAKE IT EASIER FOR HHA'S TO RECEIVE PERIODIC INTERIM PAYMENTS (PIP) AND ACCELERATED PAYMENTS.

THERE IS ANOTHER SUBJECT I'D LIKE TO INCLUDE IN MY WRITTEN STATEMENT AND THAT DEALS WITH NEW PROVIDERS AND COST CAP EXEMPTIONS.

AS EARLY AS THE SUMMER OF 1983 REPRESENTATIVES OF FAHHA, INCLUDING MYSELF AS PRESIDENT, MET WITH AETNA REPRESENTATIVES AND DISCUSSED COST CAP EXEMPTIONS FOR NEW PROVIDERS.

WE WERE TOLD THEN VERBALLY AND SUBSEQUENTLY AGENCIES HAD CONFIRMED IN WRITING, THAT PROVIDERS OPENING NEW SUBUNITS IN DIFFERENT COUNTIES WOULD BE EXEMPT FROM THE COST CAPS. AS A RESULT AGENCIES MADE BUSINESS DECISIONS TO OPEN THESE NEW SUBUNITS AND AFTER 1 YEAR HAD A COMPLIANCE REVIEW BECAUSE THEY WERE A "NEW PROVIDER." HOWEVER IN THE LATE FALL OF 1985, AFTER BEING REIMBURSED ON AN INTERIN BASIS OVER THE COST CAPS, AETNA TOLD THESE SAME PROVIDERS THEY WOULD NOT AUTOMATICALLY BE EXEMPT FROM THE COST CAPS. THEY WOULD HAVE TO FILE A FORMAL REQUEST FOR AN EXCEPTION FROM HCFA. THE CHANCE OF HAVING THE EXCEPTION GRANTED WAS SLIM, AS 95% ARE TURNED DOWN. AETNA HAS ADMITTED THEY WERE WRONG, HOWEVER THEY HAVE NO LIABILITY. THAT LIABILITY LIES SOLELY WITH THE PROVIDERS WHO DEPENDED ON AETNA TO ADVISE THEM CORRECTLY.

THE EFFECT OF THIS DECISION HAS RESULTED IN AMOUNTS OF UP TO $600,000. BEING DISALLOWED AND THE PROVIDERS BEING ASKED TO PAY BACK THIS MONEY WHICH THEY HAD ALREADY SPENT. IF THIS MISCARRIAGE OF JUSTICE IS NOT REMEDIED, MANY PROVIDERS IN FLORIDA WILL HAVE TO FILE BANKRUPTCY. IF OUR INTERMEDIARY CAN MAKE DECISIONS AND THEN CHANGE THEIR MIND 2 YEARS LATER, HOW CAN THE PROVIDERS SURVIVE?

ANOTHER COST SAVING MEASURE HAS RECENTLY SURFACED IN FLORIDA. AENTA, WILL NO LONGER DO INFORMAL REOPENINGS OF CLAIMS DENIED WHEN PROVIDERS FEEL THERE HAS BEEN AN ERROR MADE. A MAY 20, 1986 BULLETIN STATED THAT ANY DENIALS WOULD HAVE TO GO THROUGH THE FORMAL RECONSIDERATION PROCESS. THE BENEFICIARY IS THE ONE WHO HAS TO INITIATE THE PROCESS BY GETTING FORM #2649 FROM THEIR SOCIAL SECURITY OFFICE. BY THE TIME THE RECONSIDERATION SECTION REVIEWS THE CASE AND MAKES A DECISION IT CAN BE 6 MONTHS TO 1 YEAR. THEN IF THE DENIAL IS UPHELD THE BENEFICIARY HAS TO REQUEST AN ADMINISTRATION LAW JUDGE HEARING. AGAIN A LONG DRAWN OUT PROCESS. IN THE MEANTIME THE PROVIDER ONCE AGAIN MUST REPAY THE MONEY AT COST REPORT TIME. MANY OF THE CLAIMS DENIED WERE ERRORS IN OVERSIGHT ON THE PART OF THE INTERMEDIARY. I HAVE CASES ON MY DESK FROM PROVIDERS THROUGHOUT FLORIDA WHERE THE CLAIM WAS DENIED BASED ON THESE OVERSIGHTS. FOR EXAMPLE, THEY SAID THERE WAS NO ORDER FOR PHYSICAL THERAPY BUT INDEED THE ORDER WAS LISTED ON THE FORM SUBMITTED WITH THE CLAIM. THEY MIGHT DENY A CLAIM BECAUSE THERE WAS NO PHYSICIAN SIGNATURE ON THE PLAN OF TREATMENT WHEN INDEED THEY OVERLOOKED IT BECAUSE THE DOCTOR SIGNED ON THE LINE ABOVE THE BOX RATHER THAN IN THE BOX ITSELF. THESE DENIALS ARE CALLED "TECHNICAL" DENIALS AND NEITHER THE PROVIDER NOR THE BENEFICIERY CAN APPEAL THEM. THE PROVIDER MUST SIMPLY LOSE AND PAY THE MONEY BACK AT COST REPORT TIME.

THIS CONCLUDES MY TESTIMONY. THANK YOU FOR GIVING ME THE OPPORTUNITY TO APPEAR TODAY. I WOULD BE HAPPY TO RESPOND TO QUESTIONS.

Mr. PEPPER. We thank you very much, Ms. Justice, for the excellent information that you have given us about this problem.

We will ask some questions after all of the members have been heard.

The next is Mr. Mario Espino, president of American Medical Rentals of Miami.

STATEMENT OF MARIO A. ESPINO

Mr. ESPINO. Good morning members of the subcommittee and Congressman Claude Pepper.

My name is Mario Espino, Jr., and I am the president of American Medical Rentals, Inc.

I would like to take this opportunity to tell my story and thus serve the impact which Medicare's delays in reimbursement have had on our company and our industry as a whole.

Although the problem is not limited to the State of Florida, it is magnified in this State due to the enormous amount of Medicare recipients residing here and continuing to increase on a daily basis. Once again, let me emphasize that the magnitude of this problem is one of nationwide proportions.

American Medical Rentals' primary business for the past 3 years, since it was established, is the rental of durable medical equipment to homebound patients. The thrust of our business, approximately 97 percent——

Mr. PEPPER. Excuse me, what kind of equipment are you talking about?

Mr. ESPINO. Senator Pepper, we deal in anything from a standard walker, a cane, to wheelchairs, oxygen, which is very necessary for patients who have pulmonary problems. We get into ventilator work, hospital beds, standard equipment that a patient would need in order to continue quality of life after his sickness.

Mr. PEPPER. Very good, thank you.

Mr. ESPINO. American Medical Rentals' primary business for the past 3 years, since it was established, is the rental of durable medical equipment to homebound patients. The thrust of our business, approximately 97 percent, is done through Medicare assignment from these same patients.

In addition, American Medical Rentals is one of the largest independent companies of its kind in south Florida and had an even brighter outlook for the future. However, on June 23, 1986, American Medical Rentals was forced to file for bankruptcy under Chapter 11 of the Bankruptcy Code.

I am pleading with you as a last alternative in resolving the financial position of our company as well as any future ability to remain in this business. I personally feel that it is a shame that our company——

Mr. PEPPER. Wait just a minute, Mr. Espino. How much were you due from the Government for your Medicare service at the time you declared for bankruptcy?

Mr. ESPINO. Our records showed approximately $800,000 spread back over a year's time.

I personally feel that it is a shame that our company is faced with this predicament due to the Government's lack of funding to Medicare.

In addition, I foresee a flood of similar companies approaching the same situation with no evident solution in sight.

Please understand that if we are in this financial position, it is not due to our lack of ability in sustaining a business or loss of volume, but solely attributable to the fact that we have provided and continue to provide the elderly with our services while Medicare owes us over $800,000 spread back over a year's time, and our creditors insist on payment in net 30.

I can understand the Federal Government trying to cut the deficit in order to balance the Federal budget. However, in light of the necessity and extreme importance which Medicare, in particular, represents to the elderly of our country, it is difficult for me to comprehend that a bill such as the Gramm-Rudman-Hollings bill would cut right at the heart of this program.

How can we as a Nation justify not providing our own sick with the supplies and equipment necessary for them to survive on a daily basis?

I cannot accept the Medicare Program not being given prioritization over other Federal programs, such as foreign aid and defense spending.

Please let it be known that I do not oppose the necessary protection of our country and its allies. However, I strongly doubt that the Defense Department would hold payment for 7 months to providers of military equipment in order to save or make money.

Let us face it. How many Federal contracted providers would continue to provide service without a timely compensation? Yet, in our industry in particular, American Medical Rentals has continued to serve the ever growing Medicare community with the equipment and supplies necessary without hesitation of the fact that Medicare reimbursements are delayed for months and months.

Why is Medicare being forced to take such a ridiculous measure to save a supposed $130,000,000 a year, when, in reality, the savings are just an illusion?

The cost of delaying payments for Medicare providers or beneficiaries include, but are not limited to, more handling costs, more double billing, more inquiries, more incorrect payments, and not to mention the extraordinary increase in workload to an already understaffed office.

If Medicare were required to pay interest after 30 days for unpaid claims, our company alone would be owed approximately $8,000 monthly. As it stands now, we are having to make interest payments on accounts for moneys we would not owe if we had been reimbursed by Medicare as should be.

The durable medical equipment industry is hardest hit by these delays due to the expensive process it must undergo before actually being able to bill for a service it already has rendered. That is augmented by the extended delay which providers in part B Medicare are already experiencing and by the additional implemented Federal regulations to reduce Medicare expenditures.

Members of the subcommittee and Congressman Pepper, I am pleading with you, once again, to try to resolve a problem which is

affecting not only the durable medical equipment industry and other providers but, most importantly, the sick and the elderly of our country.

Our company must find relief immediately, or we will be faced with no future at all.

In closing, I would like to thank all the members of the subcommittee, Congressman Pepper, and all present for the efforts in trying to correct the problems which we have talked about today.

In addition, I would like to offer myself and my company in any way that it might deem beneficial, and I thank you once again for the time and the attention in this matter.

[Attachments to Mr. Espino's statement follow:]

Blue Cross
Blue Shield
of Florida

P.O. Box 1798
532 Riverside Avenue
Jacksonville, Florida 32231-0014
Claims and Membership Assistance: (904) 354-3331
All Other Departments: (904) 791-6111

April 16, 1986

Mr. Mario Espino, President
American Medical Rentals
7311 N.W. 12th Street
Miami, Florida 33126

Dear Mr. Espino:

On 6 March 1986, I completed the Initial Audit of your Medicare Part B automated claims which had been submitted by you. The sampling consisted of (25) claims containing (42) line items of service.

The audit was performed in order to verify:

1. the presence of appropriate documentation for the services reported on the claims; and
2. that properly dated beneficiary signatures were on file.

The following summary is provided for your records.

Signature - A properly dated beneficiary signature was on file for each claim in the sample.

Services - Documentation was found for each of the services reported.

At this time you are in compliance with Medicare guidelines pertaining to automated senders. Your next audit will be scheduled routinely.

I would like to thank yourself and your staff for the assistance and cooperation extended during the course of this audit.

Should you have any questions, do not hesitate to contact me.

Sincerely,

John M. Sullivan

John M. Sullivan, Representative
Professional Audit and Review

L09501A/04/1513L

Name ROBERT A. SCHATZMAN, ESQ.
Attorney for Petitioner
Address BRITTON, SCHANTZ & SCHATZMAN, P.A.
#3000, 200 S. Biscayne Blvd.
Miami, FL 33131-2394
Telephone: (305) 371-3100

-BKC-SMW
86-01341

[NOTE: These official forms should be observed and used with such alterations as may be appropriate to suit the circumstances. See Rule 9009.]

VOLUNTARY PETITION

☒ CORPORATION ☐ PARTNERSHIP

UNITED STATES BANKRUPTCY COURT FOR THE

....SOUTHERN..... DISTRICT OF ....FLORIDA.....

In re

AMERICAN MEDICAL RENTAL, INC.

Debtor [set forth here all names including trade names used by Debtor within last 6 years].
Social Security Number .....
and Debtor's Employer's Tax Identification No. 59-237 1812...

FOR COURT USE ONLY

Date Petition Filed .....

Case No. .....

Bankruptcy Judge .....

VOLUNTARY PETITION: CORPORATION OR PARTNERSHIP

1. Petitioner's mailing address, including county, is ....7311 N.W. 12th St., Suite 2, Miami, FL 33126, Dade County.....
2. Petitioner has resided [or has had the greater part of its business or has had its principal assets] within this district for the preceding 180 days [or for a longer part of such 180 days than in any other district].
3. Petitioner is qualified to file this petition and is entitled to the benefits of title 11, United States Code as a voluntary debtor.
4. [It is impracticable at this time to prepare a plan.] Petitioner intends to file a plan pursuant to chapter 11 [or 13] of title 11, United States Code.
5. [If Petitioner is a Corporation] Exhibit "A" is attached to and made part of this petition.
6. [Relief is sought under chapter 7 of the United States Code because the debtor is not generally paying its debts as they become due unless they are the subject of a bona fide dispute as to liability or amount.]
7. [Relief is sought under chapter 11 because the debtor is not generally paying its debts as they become due unless they are the subject of a bona fide dispute as to liability or amount. A statement of the circumstances under which the debtor should be permitted to proceed under chapter 11 is attached.]

WHEREFORE, petitioner prays for relief in accordance with chapter 7 [or chapter 11] of title 11, United States Code.

FILED

JUN 23 1986

U.S. BANKRUPTCY COURT
SOUTHERN DISTRICT OF FLORIDA
DAVID D. [illegible]
CLERK OF COURT

Signed: G. Clarence for [Attorney for Petitioner]

ROBERT A. SCHATZMAN, ESQ.
Address: BRITTON, SCHANTZ & SCHATZMAN, P.A.
#3000, Southeast Financial Center
200 S. Biscayne Blvd.
Miami, Florida 33131-2398
(305) 371-3100

[Petitioner signs if not represented by attorney.]

.....
Petitioner

Unsworn Declaration under Penalty of Perjury on Behalf of a Corporation or Partnership

I, ...MARIO A. ESPINO, JR., [the president or other officer or an authorized agent of the corporation] [a member or an authorized agent of the partnership] named as petitioner in the foregoing petition, declare under penalty of perjury that the foregoing is true and correct, and that the filing of this petition on behalf of the [corporation or partnership] has been authorized.

Executed on 6/20/86 Signature .....
MARIO A. ESPINO

Financial Statements

American Medical Rental, Inc.

December 31, 1985

Ernst & Whinney

NOTES TO FINANCIAL STATEMENTS

AMERICAN MEDICAL RENTAL, INC.

December 31, 1985

NOTE A--SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The Company is engaged in the renting and selling of medical equipment and medical supplies to institutions and individuals. Substantially all revenues are paid by Medicare and/or private insurance companies.

Inventories: Inventories consist of medical supplies and certain medical equipment held for sale and are stated at cost (first-in, first-out), which approximates market.

Furniture and Equipment: Furniture and equipment is stated at cost. Depreciation is provided by the straight-line method over a five-year period. One-half year depreciation is provided in the year of acquisition and year of disposal.

Income Taxes: Deferred income taxes arise from timing differences in reporting transactions for financial statements and tax purposes. The primary differences are the cash basis of accounting used for tax purposes and depreciation. The investment tax credit is accounted for by the flow-through method.

Unbilled Revenue: Unbilled revenue consists of amounts due from rental income and sales of equipment and supplies that is earned but has not been billed at the statement date.

NOTE B--ACCOUNTING RECORDS

During 1985, the Company lost control of its principal assets (accounts receivable, inventory and rental equipment) and its revenues. The loss of control resulted from, among other things, a computerization of the accounting records.

The accompanying financial statements are based on a reconstruction of the Company's basic financial records and include numerous estimates and assumptions. The reconstruction process included the following:

Accounts Receivable and Revenue - Beneficiary files are maintained for each customer (patient-beneficiary) and include details of equipment, rentals and/or sales. A detailed review of each beneficiary file was made to assure that the proper billing had been made. Details of the cash receipts were applied to accounts receivable. Rentals and sales revenues were adjusted to agree with the balance of the reconstructed accounts receivable and unbilled revenue.

Inventory and Rental Equipment - Inventory quantities were based on physical counts made as of December 31, 1985. Rental equipment quantities were derived from the computerized beneficiary files as of March 1986 and adjusted for additions and deletions that occurred

NOTES TO FINANCIAL STATEMENTS--Continued

AMERICAN MEDICAL RENTAL, INC.

NOTE B--ACCOUNTING RECORDS--Continued

after December 31, 1985. The inventory and rental equipment was priced using estimated replacement cost and adjusted downward to reflect (a) the bargain purchase of rental equipment (see Note C), (b) estimated cost increases that occurred during 1985 and (c) the lesser cost basis of the rental equipment that was purchased prior to 1985.

NOTE C--BUSINESS ACQUISITIONS

American Oxygen, Inc., a sister company, merged with the Company as of January 1, 1985. Due to the common ownership of the companies, no additional stock was issued in the reorganization.

On June 4, 1985, the Company acquired, at a cost of $16,643, substantially all of the assets and assumed certain liabilities of National Medical Therapeutics, Inc. (NMT), in a purchase transaction. The allocation of the purchase price resulted in a cost for the rental equipment acquired of $37,508, which was 19% of NMT's historical cost. The estimated replacement cost of NMT rental equipment included in the accompanying balance sheet exceeds the recorded cost by approximately $286,000.

NOTE D--ACCOUNTS RECEIVABLE

Substantially all of the companies' revenues are receivable from third party payors - Medicare and private insurance companies. For this reason and the accounting control problems discussed in Note B, the Company has encountered significant problems in the collection of the accounts receivable. An aging of the accounts receivable follows:

	Amount
Current	$ 67,145
30 to 60 days	57,520
60 to 90 days	56,183
90 to 120 days	57,893
Over 120 days	348,428
Other - not aged	33,199
	$620,368

Management believes that the December 31, 1985 accounts receivable are fully collectible and that an allowance for doubtful accounts is unnecessary.

MEDICARE B

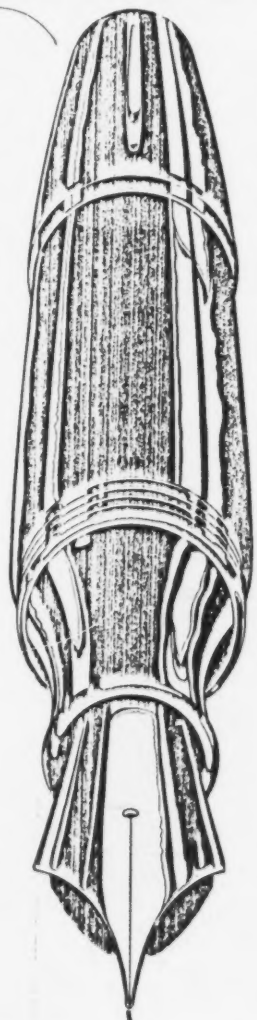
Medicare Part B Processing Delays

Recent reductions in Medicare funding for Part B contractors has resulted in claims payment delays which are raising serious concerns by Medicare beneficiaries, providers and contractors. The problem is not limited to Florida, but nationwide. Delays in claims processing are the result of Federal efforts to reduce the national deficit, such as the recently enacted Gramm-Rudman-Hollings bill, which reduced contractor funding by more than 40 million dollars nationwide, and the government directive to slow payment to maximize interest earned with the Medicare trust fund.

Adding to the processing time are increased federal regulations on how claims are processed, such as increasing the number of services requiring medical review. The cumulative effect of these changes in regulation is delaying average processing time.

There are no easy solutions to this problem and we will continue to provide the highest level of service we can. However, based on the federal government's continuing effort to reduce the deficit, payment cycle times cannot be expected to return to the levels of the past. We are continuing our effort to negotiate with the federal government for additional funding and are seeking ways to implement innovative programs to increase productivity and reduce expenses to make maximum use of the funding we have.

In order to assist us in this process, please do not submit duplicate claims or status requests until a minimum of 60 days have elapsed since initial submission. You can also expedite claims processing by insuring that the 1500 claim form is completed and accurately coded or by filing automated claims. Please see the article entitled "Standard HCFA 1500 Health Insurance Claim Forms Required" on page 12 for instructions on completing the claim form.



...home health line

SELECTED SUMMARY RESULTS OF HIDA (HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION) SURVEY OF MEMBERSHIP ON DELAYS IN PAYMENT OF CLAIMS UNDER MEDICARE PART B*

	Average Delay Rental Claim DME > $120.00	Average Delay Rental Oxygen Equipment	Average Delay Purchased DME < $120.00
CALIFORNIA			
Blue Shield	10-30 days 90 days	30-45 days 90 days	10-30 days 90 days
TransAmerica	75 days		60 days
Occidental	90 days	90 days	
CONNECTICUT			
Cigna	70-84 days	56-70 days	56-70 days
Conn. Gen. Life Insur.	120-150 days		120-150 days
ILLINOIS			
BC/BS	45-50 days	55-60 days	45-50 days
INDIANA			
BC/BS	60-120 days	90 days	90-120 days
Nationwide	59 days	76 days	59 days
MASSACHUSETTS			
BC/BS	21-28 days	21-28 days	21-28 days
NEW JERSEY			
BC/BS PA	90 days	42 days	30 days
Prudential	56-84 days	56-84 days	35-56 days
NEW MEXICO			
Equitable Life Assur.	90 days	90 days	90 days
NEW YORK			
BS Western NY	42 days 180 days	42 days 180-270 days	42 days 270 days
Empire BC/BS	42-56 days	42-56 days	42-56 days
BC/BS Greater NY	90-120 days	30-60 days	60-90 days
NORTH CAROLINA			
Prudential	42-56 days	56-70 days	
OHIO			
Nationwide Mutual Ins.	28 days	28-35 days	28 days
PENNSYLVANIA			
BS PA	28-42 days 120-180 days	42-56 days 60 days	28 days 90-120 days
PUERTO RICO			
SSS of PR	180 days	180 days	180 days
RHODE ISLAND			
BC/BS RI	90 days	90 days	90 days
TENNESSEE			
Medicare Equitable	90-120 days	90-120 days	60 days
WISCONSIN			
WPS Madison	21 days	21 days	21 days

*Delays reported to HIDA in months or weeks have been shown in days; more than one entry per carrier indicates the shortest average delay and the longest average delay reported by survey respondents for that carrier.

Mr. PEPPER. We thank you very much, Mr. Espino, for the excellent statement that you have given us.

Next, we will hear Dr. Mark Feldman, private practice physician in Miami Beach.

STATEMENT OF DR. MARK FELDMAN

Dr. FELDMAN. Good morning, members of the subcommittee and Chairman Pepper.

Thank you for the opportunity to speak before the Nation on the problems in delay of medical and surgical claims processing and payments to Medicare assignment providers.

I am Dr. Mark Feldman, a 46-year-old podiatric surgeon, who has been practicing podiatry and foot and ankle surgery in the Miami-Fort Lauderdale area since 1973 and have been accepting Medicare assignments since that time. I do so no longer as of June 24, 1986, for the reasons herein expressed.

I was president and chief executive officer of 163d Street Long Medical Group, Inc., a medical center in North Miami Beach, FL, of some 22 doctors who all accepted Medicare assignment and which filed for bankruptcy under chapter 7 of the bankruptcy code on June 24, 1986.

We were unable to collect our fees from the Medicare Program over the last 24 months in sufficient time to pay our bills and remain viable in the competitive medical marketplace.

Our 4,200-square-foot office had specialists in family medicine, ophthalmology, dermatology, general surgery, rheumatology, vascular surgery, internal medicine, cardiology, nutrition, urology, obstetrics/gynecology, endocrinology, orthopedic surgery, neurology, plastic surgery, and podiatry, all of whom accepted Medicare assignment prior to our demise.

We believe Blue Cross owes us over $300,000. Thus far, I am told, they can only find $27,000 in claims.

It was not uncommon to receive payments 12 months after services were rendered. I accuse Blue Cross and Blue Shield:

Of deliberately withholding processing of hospital and surgical charges in favor of paying small office visit charges.

Of deliberately losing claims, making resubmission necessary.

Of requesting information in a repeated fashion which was on the original claim form.

Of requesting volumes of information in the appeal process which is unnecessary to the claim's disposition, as an example, requesting of us 6 months of paperwork on every patient for 500 claims.

Designing procedures to frustrate efforts of providers to get paid and misrepresentation of electronic claims processing time. As an example, they tell you you can get paid in 7 to 14 days if you buy their computer system. In reality it is not true, and it is much longer.

Prevention of competition in the availability of computer programs so that a doctor is forced to buy their system at two to three times the price it should be.

Double and triple time for manual claims processing in an effort to force you into electronic claims submission and buying their computer systems.

Payment to Blue Cross and Blue Shield HMO's, IPA's, PPO providers over Medicare providers, making their own HMO, PPO, and IPA compete with Medicare.

Refusal to allow Medicare assignment doctors to join the Blue Cross HMO as participating providers.

Making monthly changes in the coding of claims, so numerous so as to make it impossible to keep any system of processing claims standard.

Automatic rejections of at least 20 percent of charges to maintain pay review costs.

Elimination of the 800 number for inquiries and complaints and inadequate service being instituted.

Misrepresenting to Congress that a podiatrist was being—excuse me—that a doctor is being looked into for utilization in an effort to thwart congressional inquiry of complaints about the system; all of which are intentional acts designed to keep Medicare funds floated long enough to gain interest on Federal money.

No doubt our demise caused celebration among many competitors—hospitals owned similar centers not far away. Nonprofit status assures them of decidedly different treatment under Medicare payment program than afforded our group.

Hospitals rent space to their doctors and can withstand such interminable time lags. The private practitioner cannot.

We were unable to continue to borrow money, pay our bills, pay interest on it, pay our suppliers and personnel while going through the payment-playing game.

Certainly, the system was not designed to ensure that the populace gets the same care as President Reagan.

If it is the objective that the private practitioner is to be eliminated by refusal to pay the submitted bills, then, by all means, say so. It certainly appears that this payment withholding is intentional; and the desired effect is the transference of the Medicare population to the HMO system, where profit is increased as the number and kinds of services are decreased.

I can remember when doctors who accepted Medicare assignment could not get hospital privileges. It still happens today.

Any doctor who takes assignment should be able to use any hospital which takes assignment to treat his patients. And give us Federal licenses as assignment doctors; the bad doctors can be found much easier that way.

Every doctor who performs the same service should be paid the same. The current profile system has the Medicare program encouraging unnecessary care and surgery because the more surgery, the higher the profile, and the more money paid. For example, a surgeon who does 5 gallbladders a year is paid far less than one who does 50. Their liability is the same as are the indications for treatment. The only difference is that the one is paid more for rendering the same service.

Payments are suspended while a doctor undergoes the so-called pay review process. That is the supposed review of patient care to see that the patient is appropriately treated. During the evaluating

process, which takes from several weeks to several months, the doctor is not paid except for those claims submitted through the reviewing agency.

Needless to say, this prolongs the process because the carrier also reviews the claim. The review is done by nondoctors and overseen by a general physician. Thus, the general physician is reviewing cardiology as well as neurosurgery claims.

There was a time when the review was limited to seeing that the patient received the care listed on the claim, which is highly appropriate. Now, reviewers are looking to see that the words written on the chart are what the reviewer wants, and they will not tell you what words they would like to see for each condition. Indeed, we have deteriorated into a system of creative writing.

Would you be surprised to learn that the company that the Florida review process has as its board of directors on competing medical centers is a hospital?

The reviewing companies are mandated to cut a minimum of 20 percent of the claim dollars, whether the claim is 100 percent correct or not, or lose their contract as reviewers.

Are you beginning to see why doctors don't want to take assignment?

Adding insult to injury can be fun, so it should not be surprising to learn that the reviewers will not add, as an example, a correctly charged x-ray fee for pneumonia if left off the claim inadvertently and found in review.

We now have a practitioner who loses 20 percent to Medicare coinsurance, which he must wait for the primary carrier to fund before the secondary carrier will even take the claim form for, 10 to 20 percent lost in the review process, 15 percent lost in interest on money borrowed to pay waiting time. Is there some particular reason he wants to take assignment; and who reviews the reviewers?

With such predatory payment processing and payments by the Medicare Program, it was amazing we were alive as long as we were.

The Government has attempted to persuade doctors to take assignment by outlining multiple benefits to be granted to those who will; being paid for services rendered was presumed. Clearly, this has not been the case. The grocer or car dealer will not wait an average of 3 to 4 months to be paid.

It should not matter that a doctor sells a service no one wants to buy, or that his services can be obtained by no other method.

Doctors who take assignment should be paid in 10 days for services rendered. The mechanism is in place to make certain such expediency exists.

You can decrease hospital costs by paying for in-office procedures with an allowance for surgical services similar to hospitals.

No doctor objects to review by independent, nonbiased, noncompetitive reviewers.

Forbid a carrier to send the assigned funds to the patient; make carriers pay daily interest at the market rate for claims over 10 days old; fund doctor claims, and straighten out discrepancies through later payments.

Clearly, the contract we had as assignment doctors was broken by the Government. Indeed, it appears that every assignment doctor has a cause of action against the United States Government for such breach of the contract.

It could never be said that the Medicare Program so many legislators have given so many years of their lives to see become a reality was designed to destroy access to medical care, as it has been doing for the last 5 years.

Those of us who feel assignment is sufficient implore you to fix it. Radical surgery is indicated before the patient dies, and I thank you very much for allowing me to stimulate your tympanic membranes.

Mr. PEPPER. Dr. Feldman, did I understand you had to go into bankruptcy?

Dr. FELDMAN. Yes, sir, 22 of us no longer accept assignment.

Mr. PEPPER. You say 22 doctors?

Dr. FELDMAN. Yes, sir.

Mr. PEPPER. Well, we will have some more questions as soon as we finish the panel.

Thank you very much, Dr. Feldman, for your excellent statement.

Dr. FELDMAN. You are welcome, sir.

Mr. PEPPER. Our next witness on this panel is Mr. David Nesslein, president of Mederi Home Health Care of Miami.

Mr. Nesslein

STATEMENT OF DAVID NESSLEIN

Mr. NESSLEIN. Hon. Claude Pepper, members of the Subcommittee on Health, U.S. House Committee on Aging, my name is David Nesslein. I am secretary of Mederi, Inc.

I presented a more detailed statement for the record along with supporting documents. I will read a synopsis of it at this time.

Mr. PEPPER. You are offering a statement for the record?

Mr. NESSLEIN. Yes.

Mr. PEPPER. Without objection, it will be received.

Mr. NESSLEIN. Mederi is a privately owned home health agency with three Medicare-certified offices in southern Florida, which have been providing home health services for 13 years. Mederi also manages six new agencies established in Missouri, Illinois, Arizona——

Mr. PEPPER. May I interrupt you just a minute?

Isn't it generally true that home health care is cheaper than nursing home care or hospital care?

Mr. NESSLEIN. Yes, that is correct.

Mr. PEPPER. The Government saves money when they, generally, provide home health care——

Mr. NESSLEIN. That is correct.

Mr. PEPPER [continuing]. In appropriate cases?

Mr. NESSLEIN. Yes, sir.

Mr. PEPPER. Go right ahead.

Mr. NESSLEIN. Each of the six agencies is individually licensed by the State and certified to participate in the Medicare Program. All nine of these agencies have been served as a chain organization by

a single Medicare intermediary, Aetna Life Insurance Co. of Clearwater, FL, since July 1985.

Although I recognize the subject of today's hearing is the problem that providers and beneficiaries are experiencing with fiscal intermediaries regarding timeliness of their payments, I would like to report on a severe problem that my home health agency and other south Florida home health agencies have experienced with our fiscal intermediary to illustrate the more general problem of inept performance of duties by intermediaries and the inability of providers of health care to rely on instructions issued by their fiscal intermediary.

The Health Care Financing Administration has established cost reimbursement limits for home health agencies and other Medicare providers pursuant to congressional authorization.

In order to qualify for an exception from the cost limits, a new established home health agency must file a notice with its intermediary requesting these exceptions to the caps. The intermediary then reviews the agency's request to ensure completeness and accuracy of information as specified in HCFA instructions. Once the request is complete, the intermediary is expected to make a determination of the reasonableness of the agency's cost and to submit to HCFA's central office its recommendation as to whether the agency qualifies for an exception.

The Mederi chain is presently confronted with serious financial difficulties as a result of these reimbursement policies, and of its intermediary's mishandling of the exception request.

When Aetna began serving the Mederi chain of agencies, it assured Mederi that the six new agencies automatically qualified for an exemption from cost limits. Aetna thus followed a practice of reimbursing those agencies over the cost limits where they were justified by actual costs.

On the basis of Aetna's assurances, Mederi did not submit a formal request for the exception.

In approximately November 1985, Aetna realized that it had misinterpreted Medicare regulations regarding cost limit exceptions. To correct its mistake, the intermediary initiated a program of perspectively paying the six Mederi agencies at the cost limit and retrospectively recouping moneys paid over the actual costs back to the fiscal year.

Aetna considers the amounts paid over the cost limits as overpayments to the provider. In addition, Aetna is instructing Mederi that it will have to file a formal exception request for each agency before it could reinstate payment above the cap.

Mederi submitted a formal request to Aetna for an exception from the cost limits at the end of November 1985. Due to Aetna's unfamiliarity with the exception request procedure, it took the intermediary 2 months to gather proper documentation and submit its recommendation to HCFA.

HCFA has 180 days for review, and this will be up on July 25, 1986. A decision must be forthcoming.

Despite the agencies' obvious distress, HCFA officials have indicated that Mederi's exception requests will be denied. No legitimate reasons for denial, such as failure to meet eligibility criteria set out in the Medicare regulations, have been offered.

In conclusion, Mederi has submitted this testimony to the House Committee on Aging, Subcommittee on Health, in order to illustrate the point that the Medicare Program reimbursement policies, compounded by Federal budget cuts and inept fiscal intermediaries will soon place Medicare providers in severe financial crisis. They will discontinue treating Medicare patients or, worse yet, be forced out of business.

In Mederi's case, as in many others, the Government is economizing on health care at the expense of making critical services, such as home health care, unavailable to Medicare beneficiaries.

Congressional action is necessary at this time to ensure that home health care will continue to be a benefit available to the Nation's elderly.

I would like to thank you for inviting me to speak in front of you and for having this hearing today. Thank you.

Mr. PEPPER. Yours is the case about which I spoke to Mr. Roper, I believe.

Mr. NESSLEIN. That is correct.

Mr. PEPPER. He was to give us a report later after he personally looked into your matter, and they intimated that the Aetna intermediary did not have the authority to give you permission to proceed as you were authorized to do by the intermediary, and, therefore, your proceeding would not be assured unless they found that you met the requirements for getting paid. So far as they have advised me, they have not yet made a final decision about your matter, and I am hoping that they will reconsider what their first impression was and will allow proper payment of your claim because you proceeded to render the services after being approved by the intermediary to render those services——

Mr. NESSLEIN. As we were instructed to——

Mr. PEPPER [continuing]. To the patient.

[Additional material in committee files.]

[Supporting documents submitted by Mr. Nesslein follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to: Division of Health Standards and Quality
(415) 556-3216
HS-313

Region IX
Office of the
Regional Administrator
100 Van Ness Avenue
San Francisco, CA 94102

August 28, 1985

Provider Number: 05-7697

*Kay Mann, Administrator
United Home Health Services
9333 Baseline Road
Rancho Cucamonga, California 91730

Dear Ms. Mann:

We have accepted your agreement to participate as a home health agency in the Medicare Program under Title XVIII of the Social Security Act. This letter and the enclosed Health Insurance Benefits Agreement verify your facility's participation in the Medicare Program and should be retained in your records. This agreement is effective June 24, 1985.

Your continued participation in the Medicare Program depends on your ability to achieve and maintain compliance with the Federal regulations in Title 42 of the Code of Federal Regulations. The State survey agency or the Health Care Financing Administration may inspect your facility on a periodic basis to determine your compliance with the Federal regulations.

You may submit your Medicare Part A bills to your fiscal intermediary, AETNA Life and Casualty-Florida, 2280 US Highway 19 North, Suite 144, Clearwater, FL 33518 using the above provider number.

In accordance with regulations at 42 C.F.R. 489.18, you must notify us immediately if your facility changes owners. A change of ownership includes changes in the legal status of the owner, such as a corporate merger or change of partner.

Please feel free to call Mary Defenderfer of my staff at the above number if you have questions.

Sincerely,

for Ronald S. Currie
Chief, Standards and Certification
Operations Branch

Enclosure: Health Insurance Benefits Agreement

Aetna
LIFE & CASUALTY

Provider Audit Reimbursement
Medicare Administration
2280 U.S. 19 North, Suite 144
CLEARWATER, FL 33575

Medicare

September 11, 1985

INITIAL RATE

Mr. Gary Hertz, Comptroller
P.O. Box 144536
Coral Gables, FL 33114

RECEIVED SEP 16 1985

RE: PROVIDER NUMBER: 05-7697 (UNITED HOME HEALTH SERVICES)

CONFIRMATION OF INTERIM REIMBURSEMENT RATE

Dear Mr. Hertz:

The financial data recently submitted by your facility has been reviewed by our staff. The rate(s) shown below will be used by your servicing claim office to pay all of your Medicare claims processed on or after September 1, 1985.

INPATIENT	
REGULAR	N/A
PERIODIC INTERIM PAYMENT	Part A: $22,933
Inpatient SMI	N/A
Outpatient	$64.14/visit

Subsequent to Sept., 1, 1985, your interim reimbursement rate may be adjusted based on substantiated changes or anticipated changes in your charges or costs of providing services to beneficiaries. Any additional correspondence concerning rate changes should be directed to the attention of the writer at the above address.

If you have any questions regarding the above rate(s), please let us know.

Very truly yours,

Rolando Rios

Rolando Rios, Manager
Provider Audit/Reimbursement
Clearwater Medicare Administration
Aetna Life Insurance Company
jlm

PROVIDER COPY

Ætna

Employee Benefits Division
Audit Reimbursement
2280 U.S. Highway 19 N., Suite 144
Clearwater, FL 33575
813/796-5666

Medicare

January 28, 1986

Mr. Steve Kirsh, Director
Division of Provider Payment Policy
HCFA, BERC, ORP
Room 192 East High Rise
6325 Security Blvd.
Baltimore, Maryland 21207

RE: COST LIMIT EXCEPTION REQUEST
UNITED HOME HEALTH SERVICES, INC. - RANCHO CUCAMONGA
PROVIDER NO. 05-7697
FYE: 6/30/86 AND 6/30/87

Dear Mr. Kirsh:

The above provider has requested an exception to the home health cost limits in accordance with 42 CFR 405.460 (f) (7) as amended July 2, 1984 (49 FR 27272) for newly established agency and meets all requirements necessary to request an exception. Enclosed please find copy of the exception request letter.

Provider's effective date of certification is 6/24/85 (copy of tie-in enclosed). The date of the first home visit is 6/24/85 (copy of documentation enclosed).

Projected visits for FYE 6/30/86 and 6/30/87, were submitted by the provider and are included.

Start up cost has been included in the total cost for proper analysis.

The provider is a part of the Mederi, Inc. chain. Home office costs have been projected for FYE 6/30/86 and 6/30/87. A copy of the as submitted home office cost statement is included for FYE 6/30/85 for your review.

The projected costs for 6/30/86 and 6/30/87 have been scheduled and summarized to determine a cost per visit by discipline for comparative purposes.

An explanation of services performed by the home office on behalf of the provider is enclosed.

The cost limits have been computed for FYE 6/30/86, and is enclosed. The cost limits for FYE 6/30/87 were estimated based on 6/30/86 for purposes of comparison.

Based on the information reviewed and submitted to you, we feel that consideration should be given this provider for an exception to the cost limits in accordance with current regulations.

Should you require any additional information, please feel free to contact our office.

Sincerely,

Rolando Rios, Manager
Provider Audit/Reimbursement
Clearwater Medicare Administration
Aetna Life Insurance Company
jlm

Encl.

Mr. PEPPER. Now, I would like to go back a little bit to question some of the members of the panel. Dr. Feldman, I understand that in the early days of the Medicare Program about two-thirds of the doctors took assignments.

Dr. FELDMAN. That was my understanding, sir.

Mr. PEPPER. That saved the patient, the beneficiary, the elderly person from having to make those payments.

Now, I understand that only about one-third of the doctors take assignments and, thereby, relieve the patient of the responsibility of making those payments.

Would you say that the primary reason why fewer doctors are now taking assignment is the lateness on the part of the Government in paying the claims of the assignments?

Dr. FELDMAN. Yes, sir, and I respectfully do not know that one-third of the practicing doctors in this country take assignment. I would suggest it is probably less. Certainly if the policy of not paying them for the services that they render continues, there is no incentive to stay in the program.

Mr. PEPPER. This is very important as to whether the doctor takes the assignment of the Medicare patient, isn't it?

Dr. FELDMAN. We recognize that. That is why many of us, including myself, have done it for over 10 years.

Mr. PEPPER. It is generally regarded that the patient owes the doctor for the services the doctor renders the patient.

Dr. FELDMAN. That is correct, sir.

Mr. PEPPER. But if the doctor takes the assignment, that is, accepts the finding of the Government of what is a fair fee for the service rendered, that relieves the elderly person of the responsibility of having to make that payment.

Dr. FELDMAN. That is correct.

Mr. PEPPER. If the doctor does not take the assignment but calls upon the patient, then the patient is duty bound to make the payment if he or she can, and then to recoup the 80 percent that the Government is supposed to pay from the Government. Then the patient has to go through the ordeal of lateness on the part of the Government in making the payment.

Dr. FELDMAN. That is correct, sir.

Mr. PEPPER. Now, let me ask each one of you—we are talking about the Government of the United States withholding money that is due to citizens or corporate citizens of this country.

Now, doctor, if you do not mind saying so, what is your relative net worth?

Dr. FELDMAN. Less than $50,000.

Mr. PEPPER. And how much does the Government owe you?

Dr. FELDMAN. Me personally?

Mr. PEPPER. Yes.

Dr. FELDMAN. I do not know.

Mr. PEPPER. I mean, what are your claims for your agency?

Dr. FELDMAN. Collectively the group, we believe it is in excess of $300,000.

Mr. PEPPER. Some $300,000?

Dr. FELDMAN. Yes, sir.

Mr. PEPPER. In other words, the Government is making forced loans, as it were, from citizens who are not able to make those loans.

Dr. FELDMAN. That is correct, sir.

Mr. PEPPER. Now, I would like to go through the rest of the panel. Now, yours is a national organization, is it, Mr. Nesslein?

Mr. NESSLEIN. It is a small company. It is a Florida-based company; yes.

Mr. PEPPER. About what is the net worth of your company?

Mr. NESSLEIN. The company is probably worth about $200,000.

Mr. PEPPER. And how much does the Government owe your company?

Mr. NESSLEIN. In excess of $1 million.

Mr. PEPPER. In excess of $1 million?

Mr. NESSLEIN. Yes, sir.

Mr. PEPPER. In other words, five times your net worth is exacted from you as a loan as it were, a forced loan, by the Government of the United States.

Mr. NESSLEIN. That is correct.

Mr. PEPPER. Now if you do not get reimbursement for this expenditure that you have made, what effect will it have upon your company?

Mr. NESSLEIN. Well, the companies will fail. They too will be in bankruptcy, as these other gentlemen's companies are in right now.

We have not come to that brink. We are waiting for HCFA to make the resolution here at the end of July.

Mr. PEPPER. Now, how essential to the beneficiaries of Medicare were the services that your company rendered?

Mr. NESSLEIN. They are extremely essential. These individuals have been in the hospital. We are treating them posthospital. We have about 600 patients we are currently seeing. Those patients would all be discharged into the community, have no other source of care. You know, it would be devastating for the Medicare beneficiary and very confusing for them.

They do not know of these problems. They believe in the care that we are providing them. They believe in the nurse that is coming to their house, and they do not understand or have any idea that we would have financial problems or in difficulty collecting money from the Government.

Mr. PEPPER. Ms. Davis, I believe, has gone back somewhere.

Ms. Davis, you are business manager for several Miami area physician groups. Now, what would you say is the ability of those groups to carry the loan that the Government is exacting from them, Mrs. Davis?

Come up. Can you come up to a microphone there?

Ms. DAVIS. Most of the physicians whose practices I manage did accept Medicare assignment as far as hospital bills and diagnostic procedures. That was the bulk of their income because office visits, of course, just carry you from day to day, but the money mainly comes from the hospitalization and procedures

The physicians who are my primary employers, for instance, never accepted assignment in the office for office services. Our fees are very, very reasonable, and we never had any problem. Howev-

er, when it came to hospitalization on any bill that would be, let's say, in excess of $200, then they would accept assignment.

One of my doctors goes to nursing homes, and we accepted assignment. We got to a point, like I said before, that we had to get a loan. We had no money coming in to even take care of our payroll, so I then wrote a letter to Karen Davis, who, I understand is no longer in office, but at the time was the administrator of the health care program in Washington with copies to you and Congressman Fascell, Senators Gramm, Rudman, and Hollings, and the gentleman from Blue Cross/Blue Shield, Mr. Steve Davis, who I believe is here, and I asked her for help. I do not know whether it was my letter or whatever; we did get enough payments that we could sort of get back on our feet.

Some of the other doctors, whose offices I manage, are struggling to make their ends meet.

Mr. PEPPER. How much does the Government owe your group?

Ms. DAVIS. At the time that my letter was written, my group was the one that was owed $21,491.

Mr. PEPPER. Now, would you agree with Dr. Feldman that the reason more and more doctors are not taking assignments is the lateness of the Government in the paying of the claim?

Ms. DAVIS. I think that is right now the primary reason. However, there are other factors involved why doctors hesitate to accept assignment. One of them is that Medicare is not consistent when processing claims. You submit a claim for a specific service, and they will allow so much. You submit the same service with the same diagnosis code and the same service code, and they may either disallow it, or they may pay you less, regardless of the fact that you used the same code and the same wording.

Another problem with Medicare why doctors are now not accepting assignment is, that, they go back on their word. Medicare sends notes, such as the one that states that they will pay for concurrent care provided the physicians have different specialties, and, needless to say, the diagnosis warrants this other physician's attendance.

Well, I have an example. One of my doctors is a gastroenterologist, and he was called by a GP to do a consult and follow up a patient in the hospital. The bill was submitted to Medicare January 2, 1986. The patient's diagnosis was small bowel obstruction, which is definitely a gastroenterological problem. Following Blue Cross/Blue Shield's note saying what code to use and so forth. The claim was denied. They never paid it. I have sent a million followups without positive results.

That is another reason why physicians do not accept assignment, because they never know what they are going to get in return, or when.

Dr. FELDMAN. If I may, Mr. Pepper, Congressman, the doctor who does not take assignment is in a much better position than one who does, rather than the reverse.

Ms. DAVIS. Definitely.

Dr. FELDMAN. The doctor who does not take assignment is not subject to the extraordinary review process which is designed to eliminate his claim in the first place. He is not subject to having to

borrow money to wait for payment. There are so many advantages to not taking assignment, rather than the reverse.

Mr. PEPPER. Doctor, the advantage of the doctor is the disadvantage of the patient.

Dr. FELDMAN. I understand that, sir, and I am suggesting to the Congress through this committee that the change be made so that it is advantageous to the doctor to take assignment.

Mr. PEPPER. Let me invite comment from the panel on this matter.

You know, Congress in an effort, not long ago, to reduce the cost of hospital care, which was running very, very high, far beyond the inflation figure, adopted—what is it?—DRG they called it.

Ms. DAVIS. Mm-hmm [affirmative nod].

Mr. PEPPER [continuing]. A program under which everybody who was in the hospital for the same illness would have to pay the same amount.

Dr. FELDMAN. Yes, sir. You were paid by diagnosis.

Mr. PEPPER. That is right. Now then, that meant that if a 90-year-old patient went into the hospital with a bad case of pneumonia and a 25-year-old patient went into the hospital with a light case of pneumonia, the hospital got the same amount because both of them had pneumonia. Isn't that correct?

Dr. FELDMAN. Yes, sir.

Mr. PEPPER. Now, I happened to be at the Harvard Medical School making a speech, and I had lunch with the dean of the Harvard Medical School and some of the faculty; and they thought that was ridiculous, as I do, that the hospital should be required to give the same care to those two patients and, therefore, charge the same amount.

Now, we all have had many complaints about patients that have been pushed out of the hospitals under that program when they should not have been pushed out, when their physical condition did not justify their removal from the hospital, and that decision is made by that automatic process, but I wondered if it would be wise and proper and fair for the arrangements to be made to have a—maybe it might well be a retired doctor of distinction and integrity—who would be the intermediary between the Government and the patient, and the patient's doctor.

In other words, if the patient's doctor said, "Listen, that man ought not to be removed from the hospital," or "That woman shouldn't be put out of the hospital right now. They need a few more days in the hospital," this doctor could be the intermediary, sort of the umpire, between the patient and his or her doctor and the Government and make the decision as to whether the patient should be out of the hospital or not.

Do you think it would be feasible to have such an arrangement and the same thing, I would like the same sort of an intermediary to pass on the propriety of the fee charged by the doctor. He would be sitting in an umpire capacity at that time. So if the doctors felt like they were going to get a fair hearing on what would be a fair fee, perhaps they would be more readily willing to accept assignment.

Do you think some sort of a mechanism like that might have feasibility?

Dr. FELDMAN. I would certainly applaud it if the timeframe from the rendition of service to the issuance of the check were sufficient to prevent the debacle that we are currently seeing.

Mr. PEPPER. In other words, the Government is the one party there. It is paying the bill, but it is not the only party involved in the transaction. The patient is equally involved, if not more so than the Government, and we must find some procedure by which a fair decision can be made so doctors will feel they are going to get a fair fee, and the Government will be required to pay that fee promptly after it is fixed.

Well, I was on the question of—I will go back to you now, Ms. Justice. Please, Ms. Justice, how much do they owe your organization? It is the Florida Association for Home Care.

Mr. JUSTICE. I represent 75 percent of the home care providers in the State of Florida, of which Mr. Nesslein is a member, so that his figures are in there. It is hundreds of thousand of dollars that are owed, and one of the reasons is the exact issue that he brought out. The cost cap exemption debacle, if you want to call it that, is Aetna, and I did include that in my written testimony, although I did not address it in the oral presentation.

I certainly support what he says because as president of the Florida association in 1983, I personally met with Aetna on behalf of the members and was assured by them that the new agencies would be exempt from the cost caps, and many of our agencies did get letters to that effect, and 2 years later, after reimbursing them at a rate in excess of the cost cap, the intermediary now wants the money back, and, of course, the funds have been spent in rendering care, and if they are not granted a formal exception by HCFA, which is a slim chance since 95 percent are turned down, then many of these agencies will go bankrupt.

Mr. PEPPER. Is your organization in a position financially to be the creditor of the Government of the United States to that extent?

Ms. JUSTICE. No, sir; I am in very poor financial position right now.

Mr. PEPPER. Mr. Espino, what about your organization? You are president of the American Medical Rentals. How much does the Government owe you?

Mr. ESPINO. About $800,000 going back over a year's time.

Mr. Chairman, I would like to make a comment, and I would like to include my statement in all the backup supporting documents into the records as well. I would also——

To answer your question, we were approached by a national company. We had four other offices when we were currently doing business about 6 months ago. All those have been closed. We were approached prior to that sometime in November of last year by a national firm, and they had offered us $1.5 million with a possibility of extending that on increased revenues. Currently at this time, I have got an offer for taking over the company. I did not accept the $1.5 million because at that time our business was growing. We gave the quality of care that was necessary, and I did not think it was going to be necessary nor did I want to get out of the business.

As a relationship to your comments in the diagnosis end of it and the physicians not accepting assignment, we are seeing the same in the providers' network. Ultimately I feel bad that this entire room

is not filled with Congress, because I think it is of extreme importance that we resolve this matter and it be done at once.

I think it is a fever that is out there right now in the medical industry as a whole. I think everyone that is or deals with Medicare assignment is reviewing the possibility of not taking Medicare assignment.

I cannot begin to tell you the impact that it will ultimately have on the elderly, which is the sick, if the durable medical equipment industry, which is an industry which supplies some basic equipment that the patient might need in order to continue to have a life similar to what he was having prior to his sickness—which is not a very costly industry because it is done on a rental basis. It is a one-time rental charge. If the patients—and I see them with our patients—if they are not even able to meet the small amount of money that they would have to pay for these equipments in order for them to have any type of quality of life after being in existence for a number of years and having paid taxes and supported our being here, I cannot begin to tell you the impact that it is going to have on the elderly that do not have the money to pay these simple costs to have to pay a hospital stay or to have to pay a doctor's bill, it could be $2,000 or $3,000, or a home health agency to keep them going, to try to bring them back to normal.

I really think it is a major situation that we have in front of us today. I think it is one that needs attention right away.

Mr. PEPPER. To sum up the panel's opinion, may I say that the Government, by delaying payment of just claims to the provider, is not only bankrupting or embarrassing or incapacitating the provider, but you are very directly hurting the beneficiaries of the Medicare Program, the people

Mr. ESPINO. Most definitely.

Mr. PEPPER. Is that correct?

Mr. NESSLEIN. Yes, sir.

Mr. PEPPER. Thank you very much.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I, too, certainly agree with you, sir, regarding the DRG concept in particular. I am not sure. Obviously, it has got to be looked at, and suggestions such as yours, we should have an open mind to and look at objectively. I am just wondering if any sort of a DRG concept is workable.

I know that there are many hospitals that show a pretty good profit as a result of DRG's, and I know a lot of that is probably legitimately the result of better efficiencies, but I sometimes wonder what it is doing. I do not wonder; I have seen what it is doing to the quality of health care.

Mr. Espino, do you have the option to not accept assignment?

Mr. ESPINO. Yes; we do have the option not to accept assignment.

Mr. BILIRAKIS. All right, if you did not accept assignment, what would happen to your sales?

Mr. ESPINO. The sales would still be there because the equipment is necessary in order for the patient to continue on a normal life. A hospital bed—he is not able to continue to rest in a flat bed.

Mr. BILIRAKIS. I see. Would the patient be able to afford your services?

Mr. ESPINO. Definitely not.

Mr. BILIRAKIS. Definitely not. Well, then sales would not be there then, would they?

Mr. ESPINO. Well, sales would not be there. Ultimately I see there has to be a solution to this problem because the patient would not be able to pay for it; the sales would be down, but, in essence, then what would happen to the patients?

Mr. BILIRAKIS. Well, all right. That is another question. Obviously, it is the bottom line question that we have got to tackle here and we are tackling, but, basically, if you did not accept assignment, and the same thing would be true with you Suzanne, many of these services that you say are necessary would just not be there in effect, because patients would not be able to afford it.

How long has your company been in business, Mr. Espino?

Mr. ESPINO. Approximately 4 years.

Mr. BILIRAKIS. Four years, and you have been accepting assignment during all that period of time?

Mr. ESPINO. Since the first day.

Mr. BILIRAKIS. What was your history as far as reimbursement during the first 3 years of these 4 years?

Mr. ESPINO. Well, it has been slow. Every year it has increased. Just recently in the last, I would say since March 1985, when they made additional guidelines in order to reduce the Medicare budget, which are good in essence, and I think that Medicare is trying to do some reductions, and there have been some overutilization areas, but I think their implementation of these programs have been so drastic they sort of like—they see something bad and they want to go to fix it so fast that they have gone to the opposite extreme, which is creating a tremendous problem.

In March 1985, they implemented the rental-purchase agreement for the less than $120 items, which are basically your canes, commodes, and walkers. Right after that HCFA—the second phase was supposed to be implemented sometime 4 or 5 months later; 2 months later they implemented the greater than $120 hospital bed, any item over $120 with the exception of anything that was respiratory, because you need continuous care in that area.

I cannot begin to explain the impact that these regulations have had on our industry. I think as a whole the concept and the theory is good. I think that it will save money in the future, but right now in the State of Florida, just as in other States, the effect of these guidelines are creating an additional expense on these particular years.

What has been happening is that after the third or fourth month of rental of a hospital bed, the Government is making a determination to sell the bed at 10 times the rental of that bed. So, in the fifth month now we have an additional—instead of 1 month's rental—10 month's worth of rental payments that the Government has to provide over to the supplier. That with a reduced budget, reduced amount of money at the carrier's level to process these claims, has created a very severe problem.

In this last year through March to present, we have experienced probably 2½ times the delay that was experiencing before.

Our particular industry, and I speak for the durable medical equipment industry because I believe it is at the bottom of the totem pole.

Mr. BILIRAKIS. With some brevity, please, because——

Mr. ESPINO. Yes; I will be very brief.

The durable medical equipment industry depends on a physician's signature in order to be able to provide its service. We get a call from a physician or from an institution today to provide a service today, and we go out to the home of the patient. We supply him with the equipment. We are incurring the costs of capital equipment, the administrative costs to process that patient's equipment. We prepare a prescription and then send it to a physician for him to sign it. The physician will sign it, once he has the opportunity to sign it, returns it to us via mail. We then process it once again, send it to Medicare. Medicare processes it. We wait 15 days in order for us to begin to wait on the increasing delays that exist right now under part B. So our delays are augmented by this processing that we must incur before we ever get our claim in to Medicare.

Mr. BILIRAKIS. All right, now you went into business 4 years ago——

Mr. ESPINO. Yes, sir.

Mr. BILIRAKIS [continuing]. With the plan that you would accept Medicare assignment?

Mr. ESPINO. Correct.

Mr. BILIRAKIS. All right. If there were not Medicare available, would you have gone into that business 4 years ago?

Mr. ESPINO. I think so. I think that whether Medicare exists or some other form of body exists there, I think I would have gone into the business. I was presently involved in nursing homes and the construction of nursing homes, and being involved as a project manager there, I got very concerned about medical needs. They were not as explicit or as wide or varied as they could be. I saw there was a basic care and saw a trend of home care coming into play, and home care is ultimately the way that we can save money through Medicare.

Mr. BILIRAKIS. Thank you. Dr. Feldman—well let me ask Ms. Davis first.

Ms. Davis, why did your doctors not accept assignment regarding the office visits? You said that the majority of them accepted assignment as far as the other care was concerned, hospital related care, et cetera, but why did they not accept assignment as far as the office? You said they were reasonable charges. Of course "reasonable" is open to all sorts of definitions. Why did they not accept assignment?

Ms. DAVIS. Well, mainly because we need a cash-flow. Physician practices need money just like any other concern. Now I heard somebody mention about being paid by Medicare in 10 days. I have never seen it. I have been in the medical field for 15 years. I have never seen Medicare pay in 10 days, or not even 2 weeks, and, therefore, we chose to establish our policy that for office services, which are only either an initial office visit or a followup office visit, X Rays and EKG, we do not do anything else, we felt that we would rather keep our fees low to where our patients would be able to pay, and then we file Medicare for reimbursement.

Mr. BILIRAKIS. So you file Medicare for reimbursement.

Ms. DAVIS. We do.

Mr. BILIRAKIS. Well, wait a minute. In other words, you did not accept assignment. Your patients paid, but you filed for the patient?

Ms. DAVIS. Yes, we do.

Mr. BILIRAKIS. You filled out the forms and sent them in for the patient?

Ms. DAVIS. Yes, we do.

Mr. BILIRAKIS. For the patient?

Ms. DAVIS. We still do.

Mr. BILIRAKIS. And then the reimbursement would go directly, whenever it arrived, finally, ultimately, to the patient?

Ms. DAVIS. Yes to the patient.

Mr. BILIRAKIS. OK.

Ms. DAVIS. Not only do we file Medicare, we will also file coinsurance because we feel that we owe that service to our patients.

Mr. BILIRAKIS. What is your opinion about this in the medical community; do many doctors, many business offices, file for the patient?

Ms. DAVIS. Now, there is the super bill, which in essence can be used to file with Medicare. Many doctors have a bill with a service code diagnosis, the doctor's provider number and his signature. Many offices will give the patient a paid super bill, with instructions to attach it to the Medicare, claim form in lieu of filing a claim for the patient.

Mr. BILIRAKIS. What is super bill?

Is this related to the DRG thing?

What is a super bill?

Ms. DAVIS. No, it is a bill with itemized charges and codes for services.

Mr. BILIRAKIS. In other words, it facilitates the filing.

Ms. DAVIS. Right, and these offices would just give the patient these bills instead of a completed claim form.

Mr. BILIRAKIS. So you are saying that many doctors who did not originally file for the patient are now doing so because of the facilitated process?

Ms. DAVIS. Well, no, I do not think that—I think many offices still do give the patient the service, although there are many that will only file one insurance form, if the patient requests the doctor to do it.

Mr. BILIRAKIS. I lost my father last August. Senator Pepper was very kind to acknowledge that back then. We are still, and here I am an attorney and a member of Congress, unresolved, quite frankly, in terms of filing and reimbursements and the entire picture. I do not mind telling you; it is just the process.

I do not understand how the average person can do it. How can an elderly, ill person do something like that? It is just beyond me.

Ms. DAVIS. Every office that I manage files for the patients.

Mr. BILIRAKIS. Yes, I know.

Dr. FELDMAN. Congressman.

Mr. BILIRAKIS. Yes, Dr. Feldman, go ahead, sir, because I was certainly coming to you.

Dr. FELDMAN. There is a cottage industry that has sprung up in companies that will take a claim for an individual patient, where

the doctor has or has not accepted assignment, and for a fee attempt to unscrew what——

Mr. BILIRAKIS. I appreciate that, and my father was a member of that. I think something about after a person passes away, they are no longer involved or something to that effect, but also that patient generally would have to go to that location.

Dr. FELDMAN. Oh, I do not endorse it. I do not think it should have to happen. I think it is outrageous that the system is so complicated that you have to experience what you have.

Mr. BILIRAKIS. I am experiencing it. That is right, and you are right. We sometimes go to Congress thinking we have all the answers, and we know what all the problems are. God knows we do not have the answers, but we do not. We do not even have any idea of what the problems are unless we personally experience them or via a member of the family.

Dr. Feldman, your office accepted assignment. What was it, a P.A. clinic; was that what it was?

Dr. FELDMAN. It was a group practice.

Mr. BILIRAKIS. A group practice and all the doctors, 22 of you, accepted assignment?

Dr. FELDMAN. Yes, sir.

Mr. BILIRAKIS. Did you also file for the patient as far as his supplemental was concerned?

Dr. FELDMAN. Yes, sir.

Mr. BILIRAKIS. You did?

Dr. FELDMAN. It was a secondary nightmare beyond description somewhat because there was a time when on the original claim form to the physical intermediary—the physical intermediary would forward—after they made a payment—would forward it to the secondary carrier.

Now, unless it is a Florida Blue Cross company as a secondary carrier, they will not do that. So, the time lag is that the initial carrier gets the claim. They play with it for several months, and then pay whatever they have decided to pay. They send you a check, and then you must take a copy of that and send it off to the secondary carrier and wait another several months for the 20 percent, if you choose to take assignment completely, as we did, for all services. It was our undoing.

Mr. BILIRAKIS. So, your group basically has been killed, has been punished, for accepting assignment?

Dr. FELDMAN. There is no question about it. The group has disbanded. I do not know what the practitioners do since June. I am currently looking for work.

Mr. BILIRAKIS. That was another one of my questions. You are still a medical doctor. You do not have a practice set up?

Dr. FELDMAN. As a podiatrist, no, sir, I do not currently. I am looking for positions.

Mr. BILIRAKIS. And your group accepted assignment for office visits, also?

Dr. FELDMAN. Everything.

Mr. BILIRAKIS. Everything, and how long was your group in business?

Dr. FELDMAN. The initial group was together—the initial group of three of us—it was started, I believe, about 12 years ago. I came

on board 8 years ago; 2 years ago we moved from the three-man or four-man group to a facility that was over two times the size of our original facility and took on the additional doctors to make a broad-based medical center out of it.

Mr. BILIRAKIS. All right, but had the reimbursements been relatively timely up until recently so that you all were able to handle basically the cash-flow and the lack of cash-flow, et cetera?

Dr. FELDMAN. No, sir. It was a declining process for the last 4 or 5 years.

Mr. BILIRAKIS. Is that right?

So it is not something that has just basically happened during the last year or so?

Dr. FELDMAN. Certainly not; no, sir. This has been an ongoing process for a number of years.

Mr. BILIRAKIS. If your group of 22 had not accepted assignment, would the gross volume—maybe I will say the billable charges, because obviously you say a lot of the money has not come in, you say approximately $300,000 has not been reimbursed you—would the gross volume have been considerably less because you would not have treated as many patients as a result of not having accepted assignment?

Dr. FELDMAN. Most likely. We went into the larger facility with the idea of taking assignment for the 20-some-odd of us and providing a service that was simply not available.

Mr. BILIRAKIS. Well, Mr. Chairman, I guess we can just spend hours and hours and days and months on this on this subject, and I know we will, but we cannot do it all today, can we?

Mr. PEPPER. We wish to thank this excellent panel, also, for the valuable contribution that you have made.

The committee will take a 5-minute recess while panel No. 3 is taking its position at the table.

[Whereupon, a recess was taken.]

Mr. PEPPER. Our next panel is panel 3: "Medicare Claims Processors." The participants on that panel are as follows:

Mr. Allen Spielman, executive director, Federal and tax legislation, Blue Cross/Blue Shield of Washington, DC; and Mr. Steve Davis, vice president for Medicare part B, Blue Cross/Blue Shield of Florida from Tallahassee; Mr. Robert L. Grathwohl, manager, Medicare Claims Processing Program, Aetna Life and Casualty Co., Clearwater, accompanied by Mrs. Peggy Nail, director of Medicare Administration, Aetna Life and Casualty, Hartford, CT.

First, we will call on Mr. Allen Spielman. Mr. Spielman, we will be glad to hear you.

PANEL 3—MEDICARE CLAIM PROCESSORS: CONSISTING OF ALAN SPIELMAN, EXECUTIVE DIRECTOR, FEDERAL FINANCING AND TAX LEGISLATION, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC; STEVE DAVIS, VICE PRESIDENT FOR MEDICARE PART B, BLUE CROSS/BLUE SHIELD OF FLORIDA; ROBERT L. GRATHWOHL, MANAGER, MEDICARE CLAIMS PROCESSING PROGRAM, AETNA LIFE AND CASUALTY COMPANY, CLEARWATER, ACCOMPANIED BY PEGGY NAIL, DIRECTOR OF MEDICARE ADMINISTRATION, AETNA LIFE AND CASUALTY, HARTFORD, CT

STATEMENT OF ALAN SPIELMAN

Mr. SPIELMAN. Thank you, Mr. Chairman.

I am here today representing the Blue Cross and Blue Shield Association, which is the coordinating organization for all of the Nation's Blus Cross and Blue Shield plans. Under contracts with the Health Care Financing Administration, our association and member plans, such as Blue Cross and Blue Shield of Florida, serve as intermediaries and carriers responsible for the day-to-day administration of the Medicare Program.

On a national basis, we are responsible for processing about 85 percent of all Medicare part A bills, including nearly all of the hospital bills, and——

Mr. PEPPER. We want this group of witnesses to tell us from your point of view what is wrong. What is the reason that the providers and the beneficiaries of Medicare are being treated as they have been treated and are being treated by the Government of our country?

Mr. SPIELMAN. I think I can do that, Senator. I think the major problem is, at this point, funding. There simply has not been enough money to process the ever-growing volume of claims, and I had hoped to bring some large charts with me, copies of which I have appended to my testimony, but unfortunately my express mail service had a little backlog and delay of its own.

In addition to funding, until recently there had been a Government policy of delaying payments in order to earn interest on the trust funds. However, but I am pleased to report that that policy has been rescinded, and I think that is in part due to the efforts that you have made, Senator, and other members of the congressional delegation from Florida, as well as a number of national groups including the AARP, that focused attention on this issue at the national level.

As a result of the change in policy——

Mr. PEPPER. Excuse me. Will you explain in your testimony what the role of your agencies as an intermediary is?

Explain it to the people as to how the system works and why it has gone wrong.

Mr. SPIELMAN. Basically, we perform the claims processing and review functions under a contract. The money used to pay the Medicare claims is Government money. It is not Blue Cross and Blue Shield money. It is depcsited in a bank, and we draw on that to pay the bills.

Mr. PEPPER. Excuse me; now that money is derived from a portion of Social Security contributions——

Mr. SPIELMAN. Absolutely.

Mr. PEPPER [continuing]. By the employees and the employers of the public by the overall Social Security Program. In other words, a part of the contribution that an individual pays goes to Medicare, a part of it goes to the disability program, and a part of it goes to the health care program.

Mr. SPIELMAN. That is right, and a part of that goes to administrative costs.

Mr. PEPPER. And, of course, a part of it goes to the benefit under the Social Security Program that we call the check that people get every month under what we call Social Security. But there are three programs under the overall Social Security Program:

The benefits that the recipient who is covered by Social Security gets at the end of the month; and

The next is the disability care that is provided to those who are disabled; and

The third is the Medicare.

Those are the three parts into which the payments made by the employer and the employee covered by Social Security are made.

Mr. SPIELMAN. And to explain further how this works, each year Congress appropriates how much of that trust fund should go to Medicare administrative costs, which right now are about 1½ percent of the total pot. It is a very cheap way to run a large operation. In addition to that small administrative cost, the Medicare contractor function is returning about eight or nine times the money spent on it in terms of deterred fraud, abuse, and other things. So it clearly is money well spent.

Mr. PEPPER. We will start with this question. There is enough money being paid in to meet all these claims, isn't there?

Mr. SPIELMAN. Yes; there is no question——

Mr. PEPPER. Why isn't that money being distributed?

Mr. SPIELMAN. I think part of the problem is that within the total, there has not been enough money allocated to actually process all of the claims. So, the trust fund money is there to pay these claims. It is just that we do not have enough money to process the checks. It is not unlike the situation that the IRS was facing last year where they got huge backlogs of unprocessed tax returns. We would like to avoid a similar situation from happening here.

We were very supportive of your effort to exempt Medicare administrative costs from the Gramm-Rudman process. While the Gramm-Rudman automatic cuts were overturned by the Supreme Court, the fact remains that each year Congress has to decide how much money it should allocate toward claims processing, and in the past often Congress allocated a sufficient amount, but sometimes it came too late in the year to be used most effectively.

The problem really got worse within the last year or two. Prior to that, we were not facing that same kind of difficulty.

If I could elaborate further, my written testimony, which I have included in the record——

Mr. PEPPER. Without objection, your written testimony will be included in the record.

Mr. SPIELMAN. Thank you. We feel that building up claims backlogs does not save administrative costs, in fact, quite the contrary. What it does is generate more phone calls, more inquiries, and more duplicate claims, and that adds further to the backlog. It is a

kind of catch-22, and the cost of processing and trying to work off a backlog at the end of the year through additional hires and overtime is more expensive than if the money had been made available up front in an adequate amount.

There is an opportunity for the Congress to address this issue this year. At this point we do not have an appropriation for Medicare claims processing for fiscal year 1987, which begins in less than 3 months. The process of working down the backlogs that have acculmulated this year takes time. So, we are hopeful that the Congress, both House and Senate, and the conference committee, will approve adequate funding before October 1 and that it will be made available on a timely basis so we can avoid this problem in 1987 and make up for some of the lost time in 1986.

The Blue Cross and Blue Shield Association has recommended a specific budget amount that we think will enable all the claims that will be received in 1987 to be processed plus some of the backlog that has accumulated this year. We are also asking that within the total administrative budget the amount for claims processing be earmarked. We want to avoid the situation of robbing Peter to pay Paul where claims processing, the really base of the program, gets short shrift even though there might be enough total money.

I might add in conclusion that the congressional General Accounting Office, the American Association of Retired Persons, and numerous organizations representing providers of health services have all expressed concern at the national level about the adverse effects of inadequate funding for Medicare claims processing. That concludes my statement. I would be happy to answer questions now or at the end of the panel.

[The prepared statement of Mr. Spielman follows:]

PREPARED STATEMENT OF ALAN P. SPIELMAN

Mr. Chairman, I am Alan P. Spielman, Executive Director, Federal Financing and Tax Legislation for the Blue Cross and Blue Shield Association. The Association is the coordinating organization for all of the nation's Blue Cross and Blue Shield Plans. Under contracts with the Health Care Financing Administration, our Association and member Plans serve as Medicare intermediaries and carriers responsible for the day-to-day administration of the program. Nationally, we process 85% of all Medicare Part A bills, including nearly all hospital bills, and 62% of Part B claims for medical services.

We appreciate this opportunity to provide a national perspective on the matter of Medicare payment delays and growing backlogs of unprocessed claims. We believe that the major cause of this problem is that there simply has not been enough funding for the most basic of contractor functions: claims processing. The attached chart illustrates that while the volume of Medicare claims is increasing dramatically, the funding allocated to process these claims has actually decreased.

Until recently, the lack of adequate funding was compounded by a government policy of encouraging Medicare payment delays to maximize the interest earned on the Medicare Trust Funds. I am pleased to report, however, that this policy has been rescinded. The efforts of Chairman Pepper and other members of the Florida Congressional delegation, other members of Congress, and a wide range of national organizations representing the elderly and providers of services to focus attention on this issue no doubt contributed significantly to this policy change. Also, it is important to note that HHS and HCFA have a new leadership and a new management team committed to assuring that Medicare payments will be predictable and reliable. As a result of these factors, HCFA has recently released additional FY 1986 funds for Medicare contractor activities and has told Medicare contractors that the claims payment standard

will be that 95% of "clean" claims must be paid within 27 days of receipt. The actual payment cycle could be faster depending on the contractor's system and the availability of funding. We believe that these steps represent a genuine and significant first effort to reduce the unacceptably high claims backlogs that have built up and the resulting payment delays.

To illustrate the situation, the second attached chart shows the dramatic increase that has occurred in Part B contractors' inventory of unprocessed claims. From the end of FY 1983 to the second quarter of this year, the number of claims still unprocessed at the end of the period rose from about 4.5 million to 16.5 million, a 266 percent increase. By the end of FY 1986, we estimate that there will be over 18 million Part B claims left unprocessed, practically double the FY 1985 level. Moreover, within this growing inventory, the proportion of claims that are over 30 days old is increasing rapidly. We have seen a similar pattern in the growth of claims inventories under Part A of Medicare, as illustrated by the third attached chart.

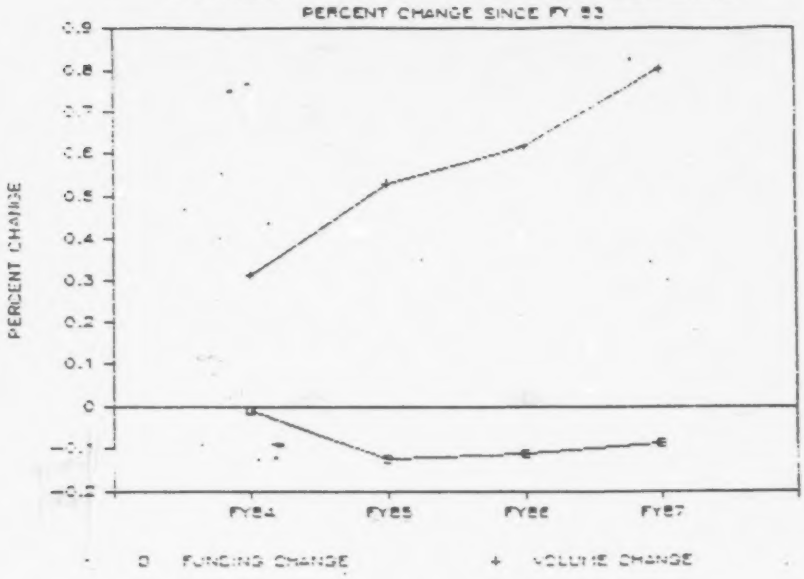
Building up claims backlogs and slowing down the processing and payment of those claims does not save administrative costs. Quite the opposite. What it does is generate more beneficiary and provider inquiries and more duplicate claims, adding further to the backlog - and to the costs of processing that backlog. Moreover, it is difficult for contractors to respond to inquiries about claims that have not yet been processed.

Reducing the large claims backlogs that have accumulated nationally will take time as many contractors hire and train additional staff and make other changes. For contractors to be successful in their efforts to reduce these backlogs, it is critical that enough money be made available and allocated for claims processing in FY 1987, which begins in less than three months. At this point, Congress has not taken action on the FY 1987 appropriations bill that would provide funding for Medicare contractor activities and other programs of the Department of Health and Human Services. We do expect that the House Appropriations Committee will take action on this bill soon after Congress returns from the current recess.

The Blue Cross and Blue Shield Association has recommended that Congress adopt a budget for Medicare contractors for FY 1987 that will enable them to process all the claims they will receive that year as well as a large proportion of the unprocessed claims left over from FY 1986. We are also recommending that the funds needed to process claims be specifically earmarked within the total contractor budget. The Congressional General Accounting Office, the American Association of Retired Persons, and numerous organizations representing providers of health services have all expressed concerns at the national level about the adverse effects of inadequate funding for Medicare claims processing.

This concludes my testimony, Mr. Chairman. I would be pleased to respond to any questions.

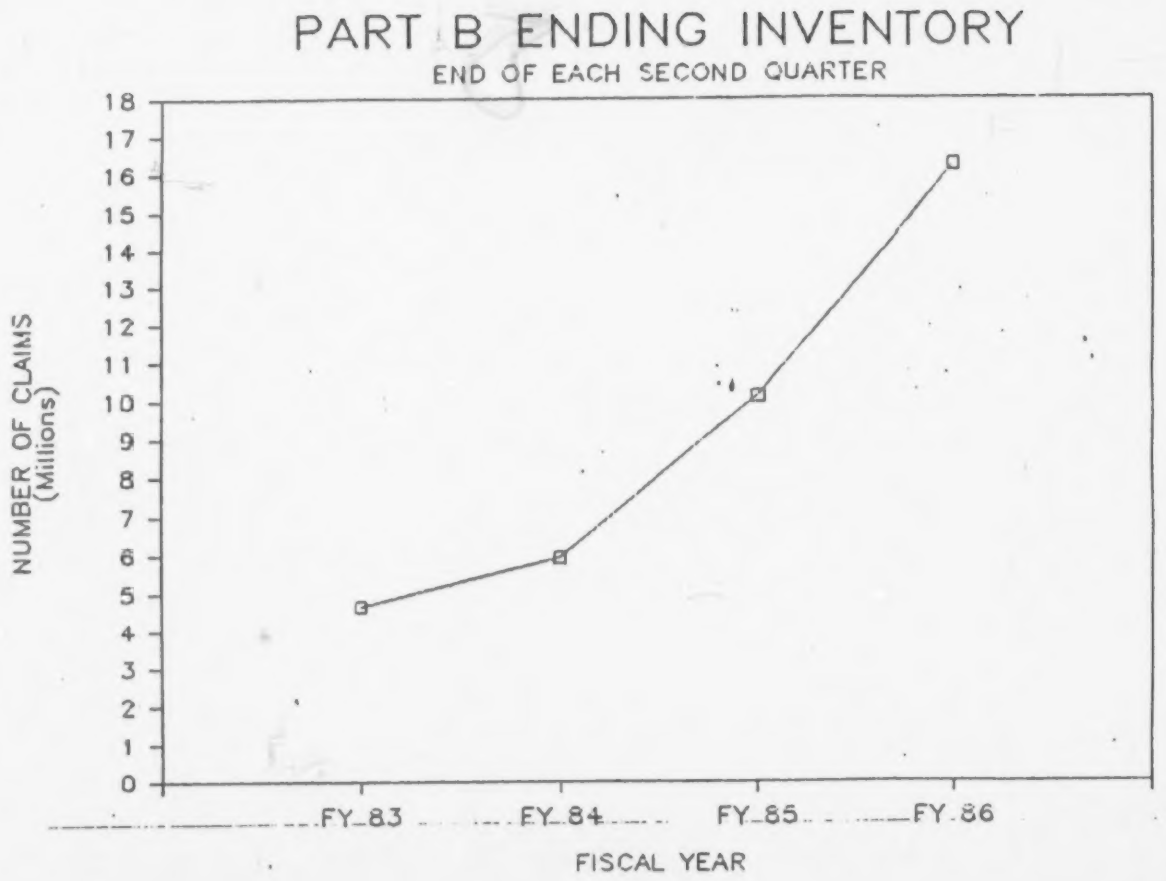
FUNDING AND VOLUME LEVELS

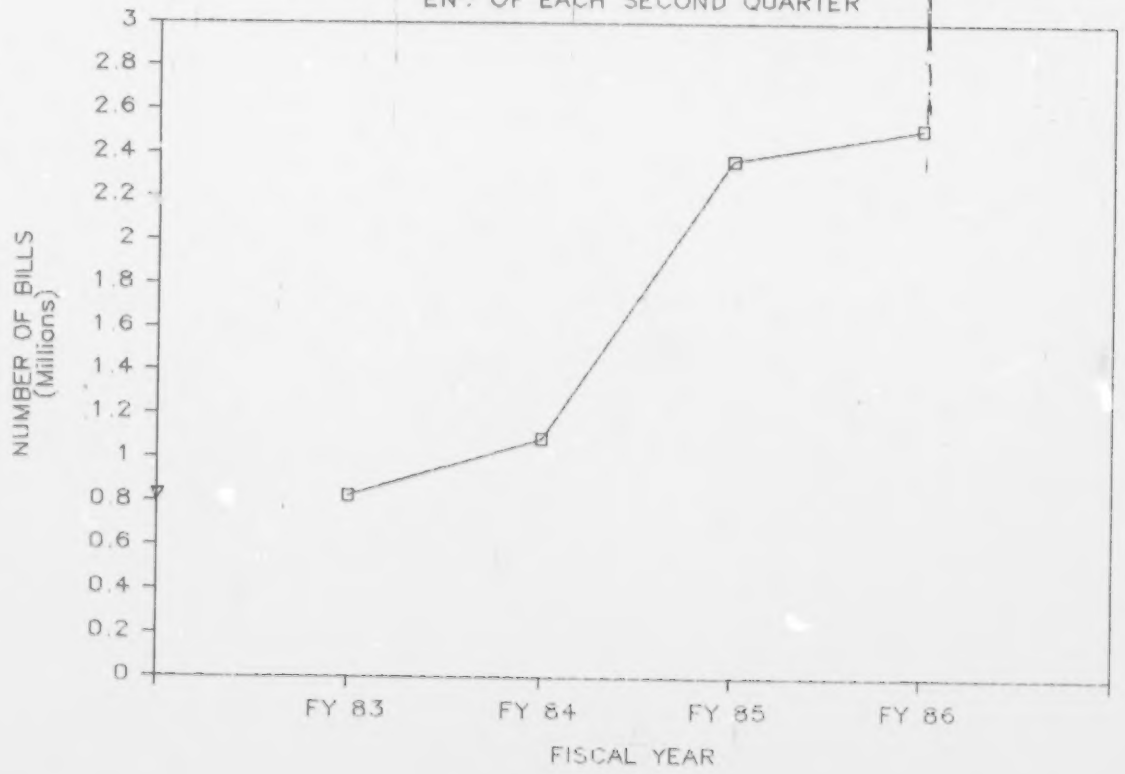


FUNDING VS. VOLUME
FY 84 TO FY 87

FISCAL YEAR	MEDICARE PARTS A & B VOLUME	PERCENT CHANGE IN VOLUME (1)	CLAIMS PROCESSING FUNDING	PERCENT CHANGE IN FUNDING (1)
FY84	278,200,000	31.18%	$566,400,000 (2)	-1.00%
FY85	324,700,000	53.10%	$501,000,000 (2)	-12.43%
FY86	343,500,000 *	61.97%	$508,200,000 (3)	-11.17%
FY87	382,100,000 *	80.17%	$522,300,000 (4)	-8.70%

* Projected
(1) Since FY 1983
(2) Administration Request
(3) As of 4/1/86
(4) HCFA Allocation


PART B ENDING INVENTORY
END OF EACH SECOND QUARTER
NUMBER OF CLAIMS
(Millions)
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
FY-83
FY-84
FY-85
FY-86
FISCAL YEAR


PART A ENDING INVENTORY
END OF EACH SECOND QUARTER
NUMBER OF BILLS
(Millions)
3
2.8
2.6
2.4
2.2
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
FY 83
FY 84
FY 85
FY 86
FISCAL YEAR

Mr. PEPPER. We will ask questions after the panel has concluded its statement.

Thank you for your excellent statement.

The next will be Mr. Steve Davis, vice president for Medicare part B, Blue Cross/Blue Shield of Florida in Tallahassee.

STATEMENT OF STEVE DAVIS

Mr. DAVIS. Good morning, Mr. Chairman and Congressman. I am Steve Davis, as mentioned, vice president of Medicare part B for Blue Cross and Blue Shield of Florida.

I would like to submit my full testimony for the record, and I will try to do a short synopsis of that in the interests of time.

I would like to start out by saying that we take very seriously our commitment to provide a high level of service to beneficiaries and providers in Florida. As a result we have achieved an exemplary performance record in administrating the Medicare Program.

However, severe budget cuts, delays in the distribution of appropriated fiscal year 1986 funds, increasing administrative requirements, and the funding prospects for the fiscal year 1987 have all combined to seriously threaten the continuation of our record of success.

Earlier, the Health Care Financing Administration, HCFA, initiated programs to gradually slow down payment of Medicare claims. With the advent of the Gramm-Rudman-Hollings Budget Act, which reduced the initial fiscal year 1986 congressional appropriation for Medicare from $978.5 million to $937 million, HCFA accelerated its position on claims payment delays.

HCFA notified us in February that there would not be sufficient funds for us to process all the claims that we would receive during fiscal year 1986. More specifically, we were advised that our fiscal year 1986 funding was being reduced by $1.3 million to assure that our claims inventory would increase to 18 days work on hand.

We immediately appealed HCFA's reduced funding level, pointing out that we believed they had significantly underestimated both our claims volume and the impact of the seasonal influx of winter residents and visitors to Florida.

We expect to receive 20.6 million Medicare part B claims during fiscal year 1986. HCFA's reduced funding level was based on our processing only 19 million claims.

We further emphasized that the discrepancy between the approved funding level and our workload would result in over 2.1 million claims pending at the end of the fiscal year, with almost half being over 30 days old. Our claims inventory would be as high as 28 workdays on hand, and our average payment time would be approximately 40 days. To put this into perspective, our part B claims inventory at the end of fiscal year 1985 was 6 days, and our average claims payment time was 14 days.

In late May, HCFA acknowledged our need and increased our funding to enable us to process an additional 1.2 million claims during fiscal year 1986. Immediately upon notification of this increased funding, we initiated plans to reduce the inventory by hiring additional staff to process claims and answer inquiries.

It should be noted that the receipt of this additional money will not immediately eliminate Medicare claims payment delays due to the time required to train additional staff.

We now project that we will process 20.2 million claims, which will reduce our projected year end inventory to 900,000 claims. However, visible improvement in the average claims payment times will not likely occur until October when the full effect of the additional staff is realized.

It is important to understand that even with the additional funding, our inventory levels will be substantially higher than they have been in past years.

An equally important issue is the fiscal year 1987 budget levels for Medicare contractors that are currently being determined by Congress.

As Mr. Spielman has mentioned, the Blue Cross and Blue Shield Association estimates that the administration's request of $957 million plus a $50 million contingency fund nationally will be approximately $140 million less than is required by contractors. In Florida, this funding shortage will be sharply compounded by the effects of carrying over the 900,000 claims we expect to have pending at the end of the fiscal year 1986, in addition to receiving in excess of 22 million claims in fiscal year 1987.

HCFA is currently attempting to implement payment guidelines which would ensure most claims are paid in 27 days. These proposed guidelines and the additional fiscal year 1986 funding we received suggest that HCFA is moving toward a more favorable claims payment policy. The fiscal year 1987 budget will be the true test of this intent.

Our primary concern is how these funding issues will impact our ability to continue to provide the service levels beneficiaries, physicians, and suppliers have come to expect.

Over the years, we have demonstrated that we have the ability and technology to process claims timely, to provide expected levels of customer service, and effectively administer the program under less than desired circumstances. However, even with our most professional and dedicated efforts, disruptions in service and slower claims payments have resulted from the delayed funding.

In closing, I would like to present the actions we believe must be taken in order to assure that claims processing service levels are maintained in Florida:

First we believe that sufficient contractor funding for claims processing and beneficiary services should be provided in fiscal year 1987 to return the program to the service levels considered adequate by beneficiaries and providers.

Second, in setting these annual budgets for contractors, HCFA should negotiate an appropriate budget level with each contractor, recognizing the contractor's local circumstances, performance, and costs during the preceding year and performance expectations for next year.

These negotiations should be concluded well in advance of the beginning of the fiscal year so the contractor can adequately plan and implement the necessary programs to achieve agreed upon service levels.

We appreciate the opportunity you have provided for us to discuss these problems and provide our recommendations, and we hope this information will prove helpful to you in your efforts.

[The prepared Statement of Mr. Davis follows:]

PREPARED STATEMENT OF STEVE DAVIS

GOOD MORNING, SENATOR, I AM STEVE DAVIS, VICE PRESIDENT OF MEDICARE B FOR BLUE CROSS AND BLUE SHIELD OF FLORIDA. I APPRECIATE THE INTEREST YOU HAVE DEMONSTRATED IN THE PROBLEMS THAT MEDICARE CONTRACTORS FACE NATIONWIDE AND THE IMPACTS THOSE PROBLEMS HAVE ON BENEFICIARIES AND PROVIDERS.

BLUE CROSS AND BLUE SHIELD OF FLORIDA SERVES AS THE CONTRACTOR FOR BOTH MEDICARE PART A AND PART B IN FLORIDA. WE HAVE BEEN DEEPLY INVOLVED IN THE MEDICARE PROGRAM SINCE ITS INCEPTION OVER 20 YEARS AGO AND ARE PROUD OF OUR ASSOCIATION WITH THIS MOST IMPORTANT PROGRAM. AS A MEDICARE CONTRACTOR, WE SERVE OVER 2 MILLION MEDICARE BENEFICIARIES; APPROXIMATELY 250 PART A PROVIDERS AND OVER 45,000 PHYSICIANS AND SUPPLIERS IN FLORIDA. IN FISCAL YEAR 1985, WE PROCESSED OVER 2 MILLION PART A HOSPITAL CLAIMS AND APPROXIMATELY 18.7 MILLION PART B PHYSICIAN/SUPPLIER CLAIMS, ACCOUNTING FOR A TOTAL MEDICARE BENEFIT PAYMENT OF OVER $4 BILLION.

ADMINISTRATION OF THE MEDICARE PROGRAM IS COMPLEX. OUR RESPONSIBILITIES AS A MEDICARE CONTRACTOR INCLUDE: PROCESSING CLAIMS FOR BOTH BENEFICIARIES AND PROVIDERS; RESPONDING TO AND DEALING WITH BENEFICIARY AND PROVIDER INQUIRIES; CONTROLLING MEDICARE BENEFIT PAYMENTS; AND IMPLEMENTING COMPLEX LEGISLATIVE, ADMINISTRATIVE AND REGULATORY POLICY CHANGES. WE TAKE VERY SERIOUSLY OUR COMMITMENT TO PROVIDE A HIGH LEVEL OF SERVICE TO THE BENEFICIARIES AND PROVIDERS IN FLORIDA.

OUR STAFF HAS ACHIEVED AN EXEMPLARY RECORD, ESPECIALLY OVER THE LAST FEW YEARS, IN ADMINISTERING THE MEDICARE PROGRAM. WE HAVE CONSISTENTLY ACHIEVED HIGH PERFORMANCE STANDARDS AS MEASURED AGAINST OTHER MEDICARE CONTRACTORS NATIONWIDE AND HAVE BEEN A LEADER IN INNOVATION WITH PROGRAMS, SUCH AS ELECTRONIC MEDIA CLAIMS SUBMISSION. HOWEVER, SEVERE BUDGET CUTS, DELAYS IN THE DISTRIBUTION OF APPROPRIATED FISCAL YEAR 1986 FUNDS, INCREASING ADMINISTRATIVE REQUIREMENTS, AND THE FUNDING PROSPECTS FOR FISCAL YEAR 1987 HAVE ALL COMBINED TO SERIOUSLY THREATEN THE CONTINUATION OF OUR RECORD OF SUCCESS.

DELAYS IN FISCAL YEAR 1986 FUNDING

EARLIER, THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) INITIATED PROGRAMS TO GRADUALLY SLOW THE PAYMENT OF MEDICARE CLAIMS. WITH THE ADVENT OF THE GRAMM-RUDMAN-HOLLINGS BALANCED BUDGET ACT, WHICH REDUCED THE INITIAL FISCAL YEAR 1986 CONGRESSIONAL APPROPRIATION FOR MEDICARE FROM $978.5 MILLION TO $937 MILLION, HCFA ACCELERATED ITS POSITION ON CLAIMS PAYMENT DELAYS. HCFA NOTIFIED US IN FEBRUARY THAT THERE WOULD NOT BE SUFFICIENT FUNDS FOR US TO PROCESS ALL THE CLAIMS WE WOULD RECEIVE DURING FISCAL YEAR 1986. MORE SPECIFICALLY, WE WERE ADVISED THAT OUR FISCAL YEAR 1986 FUNDING WAS BEING REDUCED BY $1.3 MILLION TO ASSURE THAT OUR CLAIMS INVENTORY WOULD INCREASE TO 18 WORK DAYS ON HAND.

WE IMMEDIATELY APPEALED HCFA'S REDUCED FUNDING LEVEL, POINTING OUT THAT THEY HAD SIGNIFICANTLY UNDERESTIMATED BOTH OUR CLAIMS VOLUMES AND THE IMPACT OF THE SEASONAL INFLUX OF WINTER RESIDENTS AND VISITORS TO FLORIDA. WE EXPECT TO RECEIVE 20.6 MILLION MEDICARE PART B CLAIMS DURING FISCAL YEAR 1986. HCFA'S REDUCED FUNDING LEVEL WAS BASED ON OUR PROCESSING ONLY 19 MILLION CLAIMS. WE FURTHER EMPHASIZED THAT THE DISCREPANCY BETWEEN THE APPROVED FUNDING LEVEL AND OUR WORKLOAD WOULD RESULT IN OVER 2.1 MILLION CLAIMS PENDING BY THE END OF THE FISCAL YEAR, WITH ALMOST HALF BEING OVER 30 DAYS OLD. OUR CLAIMS INVENTORY WOULD BE AS HIGH AS 28 WORK DAYS ON HAND AND OUR AVERAGE CLAIMS PAYMENT TIME WOULD BE APPROXIMATELY 40 DAYS. (TO PUT THIS IN PERSPECTIVE, OUR PART B CLAIMS INVENTORY AT THE END OF FISCAL YEAR 1985 WAS 6 DAYS AND OUR AVERAGE CLAIMS PAYMENT TIME WAS 14 DAYS.)

IN LATE MAY, HCFA ACKNOWLEDGED OUR NEED AND INCREASED OUR FUNDING TO ENABLE US TO PROCESS AN ADDITIONAL 1.2 MILLION CLAIMS DURING FISCAL YEAR 1986. IMMEDIATELY UPON NOTIFICATION OF THIS INCREASED FUNDING, WE INITIATED PLANS TO REDUCE THE INVENTORY BY HIRING ADDITIONAL STAFF TO PROCESS CLAIMS AND ANSWER INQUIRIES.

IT SHOULD BE NOTED THAT THE RECEIPT OF THIS ADDITIONAL MONEY WILL NOT IMMEDIATELY ELIMINATE MEDICARE CLAIMS PAYMENT DELAYS DUE TO THE TIME REQUIRED TO TRAIN ADDITIONAL STAFF. WE NOW PROJECT WE WILL PROCESS 20.2 MILLION CLAIMS, WHICH WILL REDUCE OUR PROJECTED YEAR END INVENTORY TO 900,000 CLAIMS. HOWEVER, VISIBLE IMPROVEMENT IN

AVERAGE CLAIMS PAYMENT TIMES WILL LIKELY NOT OCCUR UNTIL OCTOBER WHEN THE FULL AFFECT OF THE ADDITIONAL STAFF IS REALIZED. INQUIRIES WILL ALSO CONTINUE TO INCREASE AND BENEFICIARIES WILL EXPERIENCE DIFFICULTY GAINING ACCESS TO OUR CUSTOMER SERVICE STAFF THROUGH THE TOLL-FREE TELEPHONE LINES. IT IS IMPORTANT TO UNDERSTAND THAT EVEN WITH ADDITIONAL FUNDING, OUR INVENTORY LEVELS WILL STILL BE SUBSTANTIALLY HIGHER THAN THEY HAVE BEEN IN PAST YEARS.

INCREASED ADMINISTRATIVE REQUIREMENTS

IN ADDITION TO DELAYS CAUSED BY REDUCED FUNDING, CLAIMS PROCESSING TIME HAS INCREASED AS ADDITIONAL EMPHASIS HAS BEEN PLACED ON PREPAYMENT CLAIMS REVIEW AND THE REQUIREMENT TO IDENTIFY AND PREVENT PAYMENT IN SITUATIONS WHERE MEDICARE IS NOT THE PRIMARY PAYER. FOR EXAMPLE, DURING FISCAL YEAR 1986, HCFA IDENTIFIED 16 SPECIFIC SITUATIONS WHERE CONTRACTORS MUST SUSPEND CLAIMS DURING PROCESSING AND CONDUCT DETAILED REVIEWS TO ESTABLISH THE MEDICAL NECESSITY OF THE BILLED SERVICES.

PREVIOUSLY, SUCH CLAIMS WOULD HAVE GONE STRAIGHT TO PAYMENT. WE RECOGNIZE AND SUPPORT HCFA'S NEED TO ENSURE THAT ALL BENEFIT PAYMENTS ARE PROPER AND REASONABLE. HOWEVER, SINCE THESE AND OTHER ADMINISTRATIVE REQUIREMENTS ARE MANDATED WITHOUT A CORRESPONDING INCREASE IN FUNDING, CLAIMS PAYMENT DELAYS ARE INEVITABLE.

FUNDING FOR FISCAL YEAR 1987

AN EQUALLY IMPORTANT ISSUE IS THE FISCAL YEAR 1987 BUDGET LEVELS FOR MEDICARE CONTRACTORS THAT ARE CURRENTLY BEING DETERMINED BY CONGRESS. ACCORDING TO THE BLUE CROSS AND BLUE SHIELD ASSOCIATION'S ESTIMATES, THE ADMINISTRATION'S REQUEST OF $957 MILLION, PLUS A $50 MILLION CONTINGENCY FUND NATIONALLY, WILL BE $140 MILLION LESS THAN IS REQUIRED BY CONTRACTORS. IN FLORIDA, THIS FUNDING SHORTAGE WILL BE SHARPLY COMPOUNDED BY THE EFFECTS OF "CARRYING OVER" THE 900,000 CLAIMS WE EXPECT TO HAVE PENDING AT THE END OF FISCAL YEAR 1986, IN ADDITION TO RECEIVING IN EXCESS OF 22 MILLION CLAIMS IN FISCAL YEAR 1987.

HCFA IS CURRENTLY ATTEMPTING TO IMPLEMENT PAYMENT GUIDELINES WHICH WOULD ENSURE THAT MOST CLAIMS ARE PAID IN 27 DAYS. THESE PROPOSED GUIDELINES AND THE ADDITIONAL FISCAL YEAR 1986 FUNDING WE RECEIVED SUGGEST HCFA IS MOVING TOWARD MORE FAVORABLE CLAIMS PAYMENT POLICY. THE FISCAL YEAR 1987 BUDGET WILL BE THE TRUE TEST OF THEIR INTENT.

OUR PRIMARY CONCERN IS HOW THESE FUNDING ISSUES WILL IMPACT OUR ABILITY TO CONTINUE TO PROVIDE THE SERVICE LEVELS BENEFICIARIES, PHYSICIANS, AND SUPPLIERS HAVE COME TO EXPECT. OVER THE YEARS, WE HAVE CLEARLY DEMONSTRATED THAT WE HAVE THE ABILITY AND TECHNOLOGY TO PROCESS ALL CLAIMS TIMELY, TO PROVIDE EXPECTED LEVELS OF CUSTOMER SERVICE, AND TO EFFECTIVELY ADMINISTER THE PROGRAM UNDER LESS THAN DESIRED CIRCUMSTANCES. HOWEVER, EVEN WITH OUR MOST PROFESSIONAL AND DEDICATED EFFORTS, DISRUPTIONS IN SERVICE AND SLOWER CLAIMS PAYMENTS HAVE RESULTED FROM THE DELAYED FUNDING.

WE ARE ALSO VERY CONCERNED THAT, AS A RESULT OF CLAIMS PAYMENT DELAYS, PHYSICIANS AND SUPPLIERS WILL WITHDRAW OR ELECT NOT TO PARTICIPATE IN THE MEDICARE PROGRAM. THIS WOULD BE AN UNDERSTANDABLE ACTION ON THEIR PART, BUT WOULD SHIFT THE FINANCIAL BURDEN FOR HEALTH CARE EXPENSES TO THOUSANDS OF BENEFICIARIES WHO WOULD SUFFER INCREASED OUT-OF-POCKET EXPENSE AND THE ADDED CONFUSION OF HAVING TO DEAL WITH A COMPLEX PROGRAM WITHOUT ASSISTANCE.

ADDITIONALLY, THE LACK OF ADEQUATE FUNDS TO MAINTAIN EXPECTED SERVICE LEVELS IMPACTS OUR STAFF. MORALE BEGINS TO SUFFER WHEN INVENTORIES OF CLAIMS TO BE PROCESSED INCREASE WITH NO RELIEF IN SIGHT. DECREASED STAFF MORALE CAN RESULT IN LOSS OF TRAINED AND EXPERIENCED EMPLOYEES, FURTHER ADDING TO CLAIMS DELAYS.

SENATOR, WE HAVE WORKED HARD TO BUILD A REPUTATION AS A SERVICE-ORIENTED COMPANY, AND WE TAKE PRIDE IN OUR ACCOMPLISHMENTS. WE ARE DOING OUR ABSOLUTE BEST TO MEET THE NEEDS OF THE BENEFICIARIES AND PROVIDERS AND HAVE IMPLEMENTED COST-EFFECTIVE PROGRAMS TO INCREASE OUR PRODUCTIVITY. FOR EXAMPLE, WE HAVE INSTITUTED A NIGHT SHIFT OF CLAIMS EXAMINERS TO MAKE MAXIMUM USAGE OF EXISTING SPACE AND EQUIPMENT. WE ARE ALSO UTILIZING PART-TIME EMPLOYEES, PRIMARILY COLLEGE AND HIGH SCHOOL STUDENTS, IN JOBS REQUIRING LESS TRAINING. WE ALSO CONTINUE TO PROMOTE AGGRESSIVELY THE USE OF ELECTRONIC MEDIA CLAIMS BY PROVIDERS.

IN CLOSING, I WOULD LIKE TO PRESENT THE ACTIONS WE BELIEVE MUST BE TAKEN TO ASSURE THAT PROPER CLAIMS PROCESSING SERVICE LEVELS ARE MAINTAINED IN FLORIDA:

1. SUFFICIENT CONTRACTOR FUNDING FOR CLAIMS PROCESSING AND BENEFICIARY SERVICES SHOULD BE PROVIDED IN FISCAL YEAR 1987 TO RETURN THE PROGRAM TO SERVICE LEVELS CONSIDERED ADEQUATE BY BENEFICIARIES AND PROVIDERS.

2. IN SETTING ANNUAL BUDGETS FOR CONTRACTORS, HCFA SHOULD NEGOTIATE AN APPROPRIATE BUDGET LEVEL WITH EACH CONTRACTOR RECOGNIZING THE CONTRACTOR'S LOCAL CIRCUMSTANCES, PERFORMANCE AND COSTS DURING THE PRECEDING YEAR AND PERFORMANCE EXPECTATIONS FOR THE NEXT YEAR.

   THESE NEGOTIATIONS SHOULD BE CONCLUDED WELL IN ADVANCE OF THE BEGINNING OF THE FISCAL YEAR SO THAT THE CONTRACTOR CAN ADEQUATELY PLAN AND IMPLEMENT THE NECESSARY PROGRAMS TO ACHIEVE AGREED UPON LEVELS OF SERVICE.

3. IF THE GOVERNMENT DECIDES THAT IT CANNOT AFFORD THE FUNDING NECESSARY TO PROCESS AND PAY CLAIMS TIMELY, WE RECOMMEND THAT IT:

   - CLEARLY SEPARATE CLAIMS PROCESSING FROM CLAIMS PAYMENT -- IT IS MORE EFFICIENT AND LESS DISRUPTIVE FOR CONTRACTORS TO PROCESS ALL CLAIMS RECEIVED AND THEN DELAY PAYMENT THAN NOT TO PROCESS LARGE NUMBERS OF CLAIMS.

   - CLEARLY AND PUBLICLY EXPLAIN THE NEW PAYMENT POLICY.

   - ANTICIPATE THAT THE POLICY WILL GENERATE A LARGE VOLUME OF COSTLY INQUIRIES FOR A LONG TIME TO COME IN SPITE OF PUBLIC EXPLANATIONS.

WE APPRECIATE THE OPPORTUNITY YOU HAVE PROVIDED FOR US TO DISCUSS THESE PROBLEMS AND PROVIDE OUR RECOMMENDATIONS ON IMPROVING THE ADMINISTRATION OF THE MEDICARE PROGRAM. WE HOPE THAT THE INFORMATION WE HAVE PROVIDED WILL BE HELPFUL TO YOU.

Mr. PEPPER. Thank you very much, Mr. Davis, for your excellent statement.

Next, we will have Mr. Robert L. Grathwohl, manager, Medicare Claims Processing Program, Aetna Life and Casualty Co. of Clearwater.

Mr. Grathwohl.

STATEMENT OF ROBERT L. GRATHWOHL

Mr. GRATHWOHL. Good morning, Mr. Chairman and committee members.

Congressman Pepper, I am Robert L. Grathwohl, manager of the Medicare Claims Administration, Aetna Life Insurance Co., Clearwater, FL. With me today is Ms. Peggy Nail, who is the director of all Aetna's part A claims operations on a nationwide basis, and she is from Hartford, CT.

You asked us to briefly state what our role is, what we see of the problems, and what are the recommendations.

Mr. PEPPER. Excuse me just a minute. Explain, one of you, what the difference in function or else in jurisdiction is between Aetna headquarters at Clearwater and Blue Cross/Blue Shield. I thought Blue Cross/Blue Shield had the whole State.

Mr. GRATHWOHL. Under part A of the program, providers have the option to elect an intermediary, and they can exercise their selection through the secretary of HHS, and that is why we primarily have two intermediaries in the State, although I believe there are other intermediaries who may serve as, for instance, Prudential——

Mr. PEPPER. Do you all have concurrent jurisdiction or do you have a certain area that is your primary jurisdiction?

Mr. GRATHWOHL. No, sir. Each individual provider selects the intermediary of its choice.

Mr. BILIRAKIS. You mean each particular doctor or each hospital has the right to choose?

Mr. GRATHWOHL. I deal only with part A, so each individual—provider selects——

Mr. BILIRAKIS. Yes, part A, each——

Mr. PEPPER. Blue Cross/Blue Shield, you explained it also.

Mr. DAVIS. Yes, sir, Mr. Chairman. For Medicare part B, the physician/supplier side, Blue Cross and Blue Shield of Florida has the entire State of Florida, and we are the contractor for Medicare part B.

Medicare part A side, the providers or hospitals, do have the opportunity to select an intermediary, and Blue Cross and Blue Shield serves as an intermediary for a majority of the hospitals in the State, and Aetna serves——

Mr. PEPPER [continuing]. And a majority of the doctors?

Mr. DAVIS. Yes, sir, all of the doctors.

Mr. PEPPER [continuing]. And other providers?

Mr. DAVIS. Other providers, other than the skilled nursing facilities and home health providers. The skilled nursing facilities are administered—they select as well as the hospitals. Some select us; some select Aetna. Aetna has all the home health——

Mr. PEPPER. Are you and Aetna the sole two intermediaries in Florida?

Mr. GRATHWOHL. No, sir, I do not believe so. I believe——

Mr. PEPPER. Are there any other intermediaries besides you two?

Mr. GRATHWOHL. Prudential Insurance Co. does, I know, serve some home health agencies in the State because several years ago there was a designation of regional intermediaries to serve home health agencies within each State, and as part of that package, there was the option to select an alternate intermediary. There were three nationwide alternate intermediaries for home health, and I think there were two Blue Cross plans and Prudential Insurance of America. .

Mr. PEPPER. So you three are the intermediaries in Florida?

Mr. GRATHWOHL. Yes, but primarily it is Aetna and Blue Cross who are the largest ones.

Mr. PEPPER. And do the providers or the recipients of Medicare benefits in each case have the right to choose among you three?

Mr. DAVIS. No, sir; they do not. The nomination is by the provider only on the hospital side, the part A side, and that includes only hospitals, skilled nursing facilities, and home health agencies.

Under part B, the physicians, the general medical suppliers, other providers, laboratories, et cetera, they do not have the right to nominate. They deal with us, Blue Cross/Blue Shield of Florida, Medicare part 8.

Mr. PEPPER. All right. Now you may go ahead, please, Mr. Grathwohl.

Mr. GRATHWOHL. Thank you.

You will hear a central theme running through what we are saying today. The basic problems seem to be inadequate funding and particularly the certain policy that HCFA established earlier in the year of extending processing payment cycles. Those two areas primarily are at the bottom of our problems.

Our role is to try to process these claims. We primarily handle skilled nursing facility claims, home health claims, and rehabilitation center claims for primarily the State of Florida and to do this in an efficient and high quality manner.

The lack of adequate funding has impacted on both the efficient processing of the claims as well as to some extent the quality.

We speak primarily of our part A experience in Florida, but we should point out that Aetna is a multi-State/multiregional contractor, serving approximately 3,000 providers nationwide. In addition, the Aetna has part B operations in seven States and the territory of Guam.

Our company has been involved with the Medicare program since its inception in 1966. We have a longstanding commitment to the efficiency and effectiveness of the Medicare Program administration.

Aetna's Medicare department, in conjunction with the Health Care Financing Administration, has actively shared in the dynamic and difficult operational environment of these past few years. We have assisted in addressing such issues as workload management problems, potential trust fund deficits, and highly restrictive administrative budgets.

The central issue is balancing contractors' resources to our projected goal to process claims in this constricted fiscal period. HCFA and contractor representative groups have fully discussed the question of managing work and process of the payment cycles in an effort to secure the most effective process and payment cycles. This, I might add, has been in a very unstable funding period.

Many times during our discussions, HCFA and the contractors have been on opposing sides of the table. One of the issue is on the extension of the payment cycle that we were mandated with earlier.

With respect to the specific issue of increasing days work on hand, delaying of the processing in claims, contractors have clearly indicated their concerns. We believe that such a policy would not save funds and, in fact, would drain resources. Moreover, such a policy would increase the financial burden on beneficiaries and providers.

Given our position on this issue, we were pleased to learn recently of HCFA's proposed response to this question. On June 16, 1986, in correspondence to all Medicare contractors, and on June 19, 1986, in testimony before the Small Business Committee of the U.S. Senate, HCFA's Associate Administrator of Operations, Mr. Louis Hayes, announced that HCFA will hold contractors to a standard under which 95 percent of all clean claims must be processed to payment within 27 days of receipt.

This announcement made in conjunction with the release of $15 million in supplemental funding will address these problems.

While further instructions or clarifications are forthcoming on this new standard, Aetna supports this initiative, and we believe greater national contractor payment stability will result.

The issue of the impact on the Aetna operation itself is directly attributable to how much additional funding we receive out of these $15 million.

While we have managed to maintain an average of 21.5 processing payment cycle days in fiscal 1986, unfortunately we have had to sacrifice timeliness in other important areas of Medicare administration, the beneficiary and provider service areas, adjustment claims processing, other areas that are somewhat peripheral to the claims process but still very important to the providers and beneficiaries.

A balanced improvement of all work in process will present a significant challenge, particularly for the achievement of 95 percent of all claims being paid within 60 days. That is the second part of the standard that HCFA is mandating on the contractors.

The fact that our bill mix weighs heavily on skilled nursing facility claims and home health claims, which are more complex to process, will required extended medical review effort on our part, and to attain the degree of payment accuracy and still conduct comprehensive trust fund safeguard, HCFA needs to acknowledge this incremental effort and provide the appropriate funding.

Mr. Chairman, in addition to, and, in fact, perhaps more important than HCFA's commitment to the timely processing and payment, I want to repeat, is the funding. It has to be there in order for us to improve the effectiveness and quality of our claims operations, and I think the report of the Senate Committee on Appro-

priations, which accompanied the fiscal year 1986 appropriation for Medicare contractors, accurately sums up our position on this issue in saying——

> The committee believes that an adequate funding level for Medicare administrative functions is essential to maintaining the integrity of the Medicare Program and to assure that timely and accurate processing of claims occurs. Further, the committee believes . . . that the first priority should be given to claims payment and to reduce claim backlogs and to prevent any further deterioration in the quality and timeliness of claims processing functions.

And with this we fully concur.

We are hopeful that appropriations in this area for fiscal year 1987, as enacted by Congress and implemented by the administration, will appropriately and adequately address this issue. We are aware that this is a key concern to numerous Members of Congress, including yourself. Your input into this process, through holding hearings such as this one and through conversations with your colleagues in Congress, will clearly assist in achieving that goal.

Thank you, and we will try to answer any questions you might have.

Mr. PEPPER. Thank you very much, Mr. Grathwohl.

Next, we will hear from Ms. Peggy Nail.

Ms. NAIL. I am not prepared to give a testimony. I am just here to answer any questions you might have, Congressman.

Mr. PEPPER. You have no statement to make?

Ms. NAIL. No, I do not really have a statement. I am just here to answer any questions you might have.

Mr. PEPPER. You are two of the three intermediaries in Florida, serving something like 2 million beneficiaries. I understand 1 out of every 15 Medicare beneficiaries in the United States live in Florida, so your organizations have a very great responsibility.

Now is it the fault of your intermediaries—well, let me back up—are these victims and providers telling the truth about the failure of the Government to pay them promptly what they are entitled to receive?

Are they telling the truth, or is that rare on the part of the Government in making these payments; is it, or is it not a problem?

Mr. GRATHWOHL. I think that their representation of the situation is fairly accurate based on——

Mr. PEPPER. Would Blue Cross/Blue Shield agree?

Mr. DAVIS. Yes, sir, we agree that what they pay——

Mr. PEPPER. Well, now, is it the fault of your intermediaries that those conditions exist?

Mr. GRATHWOHL. No, sir, I believe that the two central issues are the inadequate funding levels and the primary singular policy of extending payment cycles to 12, 18, 22 days.

Mr. PEPPER. There is the money available to make the claims if it is promptly provided; is that true?

Mr. GRATHWOHL. I think there is no problem with money being in the trust fund to finance the benefits part of the program.

Mr. PEPPER. Well, now, according to your knowledge, the agency through which the Federal Government operates in the payment of these claims is HCFA; is that it, Health Care Financing Administration?

Mr. GRATHWOHL. That is correct, yes.

Mr. PEPPER. Now then, has the Government deliberately adopted a policy to your knowledge delaying the payment of claims?

Mr. SPIELMAN. Perhaps I can answer that. They did, but they have now reversed that policy, and they have assured us that they will not force contractors to delay claims just for the sake of delay.

The sole issue is, "Do they have enough money to bring the timeliness of claims processing back to where it used to be?" Several years ago we did not have all of these problems and these complaints.

Mr. PEPPER. Now when did the Government adopt that policy of delay in the payment of claims?

Mr. SPIELMAN. Well, informally it has been in force since the beginning of the year. I think it was not until April that they announced that that was the policy, but, again, just recently——

Mr. PEPPER. In other words, it was a deliberate policy of the Federal Government to delay the payment of claims?

Mr. SPIELMAN. It was, sir, and in June new leadership put in place in HCFA, and they immediately took action to reverse that policy, and we are very pleased with that. Dr. Roper has expressed his commitment to, trying to address this problem within the budget that they have. It is a problem that takes time to address.

Mr. PEPPER. Due to the fact that there is a large backlog of claims.

Mr. SPIELMAN. Absolutely, somewhere around 23 to 25 million claims are backlogged nationwide.

Mr. PEPPER. Well now, what did the Government give as the reason for adopting a positive policy of delaying the payment of claims?

Mr. SPIELMAN. They had had some reports that suggested that that could save them as much as $130 million in interest—in other words more interest earned on the trust fund. This came up in hearings before Congress.

Mr. PEPPER. In other words, if they left the money that should be used in the payment of claims in the trust fund, it would derive interest.

Mr. SPIELMAN. Yes.

Mr. PEPPER. And, therefore, the fund would be benefited at the expense of the providers and the beneficiaries of Medicare in the country?

Mr. SPIELMAN. Yes. There is no free lunch. What is a savings to the funds is a cost to the providers and beneficiaries who are left having to finance delayed payments, and we pointed that out.

Mr. PEPPER. Well now, does HCFA recommend to Congress the amount that should be appropriated by Congress for administrative expenses for the Medicare Program?

Mr. SPIELMAN. Yes, they do, and as we have indicated earlier, we believe that that recommendation is insufficient for 1987. We believe that additional money should be provided.

Mr. PEPPER. Has Congress appropriated the money requested by HCFA?

Mr. SPIELMAN. The Congress has appropriated more. For 1986, they appropriated a significant amount more, but, again, that was prior to Gramm-Rudman. Most of that money was cut out under

Gramm-Rudman because there was no exemption for Medicare administrative costs. At that time the administration also requested, but did not receive approval for an additional $2 million cut. For 1987, which is what we are looking at now, they have recommended a funding level which we think is too low.

I might point out that HCFA itself does not make that decision. They make recommendation and it goes through OMB, and the entire Government process. The President's budget, submitted in February, did recommend a funding amount for 1987 which we think is inadequate.

Mr. PEPPER. In other words, it is not the fault of Congress. Congress has appropriated whatever the HCFA people recommended and something more.

Mr. SPIELMAN. Absolutely.

Mr. PEPPER. So what we have got to do is to look at it ourselves and see how much ought to be appropriated and then use our own judgment. We apparently are not able to rely on the recommendation of HCFA as to the amount needed.

Mr. SPIELMAN. I think that is accurate.

Another key feature is the timing of it. The contractors are now budgeting for 1987, and they are budgeting at very low levels because there is not a congressional appropriation yet. So if it is adequate, it is also important that it be in time, that we do not go through the next fiscal year——

Mr. PEPPER. How much leadtime should there be in the appropriation to make it so that the funds would be available as you need them for distribution?

Mr. SPIELMAN. Well, basically, just before the fiscal year begins in October, and historically that has usually not been met. It is usually well into the fiscal year.

We are right now on the fifth optional budget for 1986, and we are 9 or 10 months into the fiscal year. So if Congress appropriated an adequate amount, and HCFA took that money and made budget decisions before October 1 of this year, I think it would help significantly in solving this problem.

Mr. PEPPER. Well now, we will be moving shortly into, I think, the consideration of the other appropriation bills, and then we usually have sort of a catchall bill, a supplemental appropriation, which comes sometimes after the other appropriation bill. So, now we can be on the alert to try to see to it that the money that is necessary, an adequate amount for administrative expenses is available by the first of October for use by you intermediaries.

Mr. SPIELMAN. That would be a Godsend, Congressman Pepper.

Mr. PEPPER. You said HCFA has not recommended an adequate amount so far for 1986 or 1987?

Mr. SPIELMAN. Yes.

Mr. PEPPER. Well now, would you all make recommendations that you think would be a proper amount for the administration of the program?

Mr. SPIELMAN. Yes, and I would be happy to share them with you. We did share them with the Appropriations Committee and Mr. Natcher, who chairs the Labor HHS Subcommittee. We have detailed funding recommendations that they have reviewed.

Mr. PEPPER. Do you have that data here now? Today?

Mr. SPIELMAN. Yes, I can submit that for the record.

Mr. PEPPER. Submit it for the record, if you will, and then will you also send to me and to the other two members who are here today your recommendation as to the amount that should be appropriated by the Congress for fiscal 1987 to meet the expenses needed for the administration of the program.

[Administrative expense recommendations follow:]

Medicare Contractor Budget
FY 1987 Comparisons
(Dollar Amounts in Millions)

	HCFA/OMB FY 1987	BCBSA Estimates: Recommendation	Recommended Increase (Decrease)	Explanation Code	Alternative I	Alternative II
Payment Safeguard						
Medical Review - A	$ 43.6	$ 36.3	($7.3)	A	$ 36.2	$ 35.9
Medical Review - B	47.0	67.2	20.2	B	67.2	67.22
	$90.6	$103.5	$12.9		$103.4	103.1
Provider Audit						
Desk Review	$17.9	$ 24.6	$ 6.7	C	$ 24.6	$ 24.6
Field Audit	49.4	67.0	17.6	D	67.0	67.0
Settlement	13.3	16.8	3.5	E	16.8	16.8
Total Audit Related	$80.6	$108.4	$2.8		$108.4	108.4
Medicare Secondary Payer	$ 28.1	$ 31.9	$ 3.8	F	$ 31.9	$ 31.9
Total Payment Safeguards	$199.3	$243.8	$44.5		$243.7	$243.4
Productivity Investments	$29.7	$40.0	$10.3	G	$40.0	$40.0
Claims Processing						
Bill/Claims Payment	$522.3	$601.8	$79.5	H	$588.4	$575.8
Provider Reimbursement	23.8	29.1	5.3	I	29.1	29.1
Printing	1.5	1.5	0.0		1.5	1.5
Fixed Price/Incentive Contracts	62.0	62.0	0.0		62.0	62.0
Total Claims Processing	$609.6	$694.4	$84.8		$681.0	668.4
Beneficiary and Provider Services						
Hearing and Reconsiderations	$ 26.4	$ 30.0	$3.6	J	$ 30.0	$ 30.0
Elim. Favorable Waiver Presumption	12.8	5.0	(7.8)	K	5.0	5.0
Beneficiary Communications	63.8	65.3	1.5	L	75.0	75.0
Participating Physicians	15.2	18.0	2.8	M	18.0	18.0
Total Beneficiary & Provider Services	$118.2	$118.3	$0.1		$128.0	$128.0
Operating Funds	$ 956.8	$1,096.5	$139.7		$1,087.7	$1,079.8
Contingency Funds	50.0	50.0	0.0		50.0	50.0
	$1,006.8	$1,146.5	$139.7		$1,137.7	$1,129.8
TOTAL CONTRACTOR BUDGET	$1,007.0	$1,147.0	$140.0		$1,137.0	$1,130.0
Workload Consequences						
Part A: Bills Processed	65.8 mm	70.2			68.7	67.6
Days Work on Hand	22.9 days	6.0			16.0	16.0
Part B: Claims Processed	316.3 mm	339.9			323.3	324.7
Days Work on Hand	24.6 days	6.0			12.0	18.0

Mr. SPIELMAN. Basically, we are recommending $140 million more than what the administration had recommended, but I can give all the details in written material.

Mr. PEPPER. Now, if you had that amount, what would it enable you and the intermediaries to do?

Mr. SPIELMAN. Absent any policy to the contrary, it should enable us to return service to where it was about a year ago before this problem really emerged.

At the end of 1984——

Mr. PEPPER. How much delay would there then be in the payment of claims?

Mr. SPIELMAN. Well, they did not measure things that way, but I think you are talking around 10 to 15 days, something like that historically.

They used to measure inventory——

Mr. PEPPER. We could be assured that within the legal limit of 30 days, under which the claims are required to be paid, they could be paid if your recommendations as to the amount were provided?

Mr. SPIELMAN. Well, under the program ever since the beginning, there are always certain claims, which, for whatever reason, are the outlier claims that need extensive development. So, under no program, including our private business, can you get a 100 percent of everything paid within 30 days. However, I think with our funding recommendation, you would see a substantial improvement and a minimum number of those claims that need further development, beyond the 30 days.

Just judging by the inquiries that we have received and you have received, I suspect a lot of the complaints would subside.

Mr. PEPPER. We are pleased to have a confirmation of our opinion that you intermediaries have done a good job and that it is not your fault that these delinquencies in payments have arisen, and we appreciate very much your help in giving us the knowledge that would enable us to try to correct the deplorable present situation that we have.

Have you anything else to state about how we can avoid the recurrence of this thing, any additional statement that you would like to make on that subject?

Mr. SPIELMAN. No; I think you have summed it up perfectly, Senator. It is funding. It is assuring adequate and timely funding.

Mr. PEPPER. Well, thank you very much, gentlemen. You made an excellent—wait just a minute now.

Mr. Fascell.

Mr. FASCELL. Thank you, Mr. Chairman. I just wanted to get one item straight on the record on the recommendation by HCFA and OMB and to determine whether or not HCFA actually requested sufficient funding, based on the best estimates of the intermediaries, and then whether or not that was cut back by OMB. That is what I am trying to determine right now.

Mr. SPIELMAN. I do not think we would be able to speak to that. You might ask the HCFA witness.

Traditionally, Governmentwide it is not unusual, as you well know——

Mr. FASCELL. No; I understand that. That is the reason I asked the question. I thought maybe you knew, since you had already discussed this matter with the Appropriations Committee.

But suffice to say, you have told us that you need $140 million more for administration purposes in fiscal 1987, than is in the budget.

Mr. SPIELMAN. The budget has not yet been decided upon—the $140 million is the amount over the administration's recommendation.

Mr. FASCELL. Over the administration's recommendation, the administration's budget.

Mr. SPIELMAN. Yes.

Mr. FASCELL. So, Congress has not dealt with that yet in terms of the appropriations bills.

Mr. SPIELMAN. That is right, and I would point out that there is an overall savings to the Government in this area. Every dollar you put in this budget is returning $9 dollars to the Federal trust funds because those moneys prevent duplicate and improper claims from being paid. Administrative activities also prevent payments from being made for claims from people who are not eligible for Medicare. There is a savings. It is a net savings of $9 to $1.

Mr. FASCELL. Well, I do not know if I will get a chance to vote on it, things being the way they are with respect to the Appropriations Committee, but I certainly would support full funding for processing. I have no problem with that.

The decision we will have to make is, since we have this dollar-for-dollar trade off in the budget, where does the money come from. I would be perfectly willing to add it on because that has been one of the fights that we have had in the Congress all along with this administration is in making decisions about what should be top priority.

I have no problem, and I know my colleagues have no problem in making health care a top priority. If we have one reason at all for Government, certainly in this program, it would be to get the benefits to the beneficiaries and to the providers. It does not make sense to me to cut back on that program.

The next thing I need to know is, given this additional $140 million for fiscal 1987, given a 22 million claims backlog, how long will it take to clean up the backlog?

Mr. SPIELMAN. I cannot give you a precise figure on that.

Mr. FASCELL. Just guess.

Mr. SPIELMAN. I would think it would be—if the money were allocated in the beginning of the year—I would think it would take at least half of the year to work the backlog off. It may take the entire year because, as I mentioned earlier, it is a lot harder and more expensive to work off the backlog than it is to process claims up front when they come in because——

Mr. FASCELL. It is very important to get all of the money necessary and to get it at the beginning of the fiscal year. It is not going to do you much good to get it next spring.

Mr. SPIELMAN. Absolutely, and we are very concerned about the future. We think there is a possibility that we may not get an appropriation bill and get a continuing resolution instead. If the Medicare administrative budget is leveled out at this year's funding,

not only are we not going to be able to reduce the backlog, but I suspect it will probably get worse. So we are very concerned about it.

Mr. FASCELL. Well, that is a very genuine and real concern. The way it stands right now, if I were going to guess and speculate, I think we are going to go to a continuing resolution. I think what is going to happen is exactly what you have suggested, and that is that we will flatten it out and go at the current rate, which would be a disaster. We are going to have to be on the lookout for that, and we will do whatever we can to make sure that does not happen. I guess you have already expressed that concern to the Appropriations Committee. Am I correct?

Mr. SPIELMAN. Yes, and I might point out, too, with respect to your concern about the overall budget, it is kind of an accounting artifact. Theoretically you shouild add back those $9 that come back, but a lot of people do not count that——

Mr. FASCELL. In terms of revenue, you mean?

Mr. SPIELMAN [continuing]. In terms of revenue, you are not really adding, you are not pressuring the budget. In fact, you are helping deficit reduction, but, unfortunately, they do not count it that way.

Mr. FASCELL. I have one other question, Mr. Chairman. I am trying to get clear in my mind with respect to the administration problem as to whether there are any statistics which would help us in the determination of the process where one intermediary is processing under part B and a different intermediary is processing under part A.

Mr. SPIELMAN. Well, the programs are different, and I think——

Mr. FASCELL. They are not different to me. I choose the doctor and I choose the hospital, right? As far as I am concerned, it is the same illness. Now I wind up with two processors.

Mr. SPIELMAN. I think for the most part——

Mr. FASCELL. You understand what I am getting at, don't you?

Mr. SPIELMAN. Yes. Prior to the funding problem, I do not think there was a problem in coordination here in Florida. These gentlemen could speak to it more specifically.

Mr. FASCELL. OK, that is what I was asking. Has anything developed administratively, operationally, statistically that would indicate that a multitude of processors or division of processors between the parts had any significant impact on administration. The answer is no.

Mr. SPIELMAN. Not to my knowledge, and I think they can speak to the Florida situation. I do not think it has been a part of the problem at all.

Mr. FASCELL. OK, thank you very much. Thank you, Mr. Chairman.

Mr. PEPPER. Thank you, Mr. Fascell.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. First, sir, I would like to welcome Mr. Grathwohl here. He comes from Clearwater, the largest city in my district, sparkling clear water as we call it.

Mr. GRATHWOHL. Thank you, sir.

Mr. FASCELL. Part of God's country.

Mr. BILIRAKIS. Part of God's country; all of Florida is part of God's country, let's face it. Makes you wonder sometimes why we work so hard to leave Florida for about half the year.

I would ask a general question to all of you. Are reimbursements to the patient more timely than reimbursements to the provider? What is the history there?

We have heard testimony from elderly who suffer many difficulties because they have not received reimbursement, and yet their reimbursement in general appears to take less time, or does it?

Mr. DAVIS. On average, the time it takes to get a claim paid to a beneficiary who is filing on an unassigned basis is generally slightly longer because those claims typically are not as completely filled out as one coming from a physician's office. So the timeliness of those, while they are generally the same, if I had to guess I would say that the unassigned claims completed by the beneficiary and submitted will be somewhat longer.

Mr. BILIRAKIS. They take longer, not shorter then. They take a longer time?

Mr. DAVIS. I think nationally it is probably about 3 or 4 days longer, historically.

Mr. BILIRAKIS. Well now, Senator Pepper got into this, into the meat basically of the system. Why does, and certainly I am not taking pot shots at you gentlemen, I agree with the Senator that you certainly do not appear to be, at least principally, at fault for these delays, et cetera; and I am not antiinsurance company, but I ask the question: why are intermediaries necessary?

Why has somebody determined that the reimbursements have got to take place by way of an intermediary, an inbetween person, if you will?

Why cannot the savings that Mr. Spielman referred to, the $9 in savings for every $1 spent, be accomplished by HCFA or by some agency of the Federal Government, if you will the Federal employees, and instead has to go through intermediaries?

Mr. SPIELMAN. Let me comment on that from two perspectives. The Government tried that, and they had their own claims processing unit and found that it actually was less efficient than letting the private sector do it.

Another historical perspective on that, in 1965 when Medicare was enacted, and I am sure the Senator could elaborate much better than I on this, there was a desire to build upon existing relationships that the insurance companies had with the providers' sector as well as the public, in order to make Medicare a mainstream approach. And so rather than set up a new bureaucracy, it was decided to do that, and, I might say, I hark back to my statistics. The cost of administration under Medicare, I think, is probably the best deal that the Government ever had. 1.5 percent of the total budget, which is better than what insurance companies do——

Mr. BILIRAKIS. Your earnings is the result of being intermediaries or part of that 1½ percent; is that right?

Mr. SPIELMAN. That is right. The total contractor budget, if that is what you mean by "earnings," the cost of administration.

Mr. BILIRAKIS. All right, so the 1½ percent is the total contracted budget. That does not include HCFA. That does not include Federal employees that are involved in the process, or does it?

Mr. SPIELMAN. I think if you add that, it gets to be 2½ percent, significantly low.

Mr. BILIRAKIS. That is a lot better than, I guess, March of Dimes and things of that nature.

Now what is the scenario here?

Do you sit down—you are a private enterprise, and thank God for private enterprise, and I think the private sector if it were more involved, quite frankly, we would have a much more efficiently running republic. There is no question about that.

But how does it come about; do you sit down at the beginning of every fiscal year, at the beginning of every calendar year, whatever the situation is, and negotiate with the Federal Government?

I mean, do you just basically take from the Government what they say they are going to allow you to do this job?

Mr. SPIELMAN. Actually, we would like to sit down and negotiate and that is what the arrangement is supposed to be. Unfortunately, what we have seen is a really a departure from negotiations. In the last year or so, HCFA has set by a formula what the budget will be, and it does not take into account the individual contractor's circumstance.

There is no negotiations. It is a fixed formula that is assigned, and the GAO, for example, found that that was inconsistent with congressional intent.

We would like to see a return to that, that before the fiscal year there is a sit down to negotiate what the situation is and get this all arranged, the performance standards and what have you in advance.

Mr. BILIRAKIS. If that were to take place, would the figure increase from 1½ percent?

Mr. SPIELMAN. No, absolutely it would not. Absolutely not, in fact, when that negotiation was taking place, the cost per claim was dropping down significantly.

When the program first started, it was not 1½ percent, it was higher. I do not know what the figure was. We have seen a consistent improvement in productivity while claims volume and the complexity of the program is going up.

Mr. BILIRAKIS. What would go into the negotiation other than money, the type of work that would be accomplished?

Mr. SPIELMAN. Well, yes. The gentleman from Aetna pointed out his particular mix of bills—but you also have to look at the nature of the contractor's computer system, what special programs or initiatives perhaps HCFA and the contractor have implemented in the past, and unique circumstances. For example, seasonal fluctuations in the population of beneficiaries is probably a significant problem down here.

Mr. BILIRAKIS. But during the time of the forced delays that you have testified to, when HCFA said to spread out the period of processing claims, did you lay off personnel?

Mr. DAVIS. I will speak for Blue Cross/Blue Shield of Florida.

No, sir, we did not lay off personnel. What we did was we tried to match our work force with our budget, and we did that in a sort of

way to not get in a position of having to lay off personnel. We were prevented from hiring additional people because ws did not have the budget for the expected claims volume, but, fortunately, we were not in a position where we had a lot more people than we would have been able to afford.

Mr. BILIRAKIS. But the dollars that you received apparently had been determined prior to when that decision was made, and, consequently, those dollars stayed the same in spite of the fact that by stretching out the claim paid period probably meant less effort or less man-hours put into it by your employees. Isn't that right?

Mr. DAVIS. It would have been the same.

Mr. BILIRAKIS. They put in the same amount of hours?

In other words, it takes just as long to process a claim that is going to be spread out over a mandated 2-month period of time as it does for a 3-week period of time?

Mr. DAVIS. That is correct. The claims processing stays is the same. The problem that we were faced with was the expectation of receiving many more claims than we were having resources in place to process, and the effect then was that we were not processing the claims as timely, and they began to build up.

Mr. SPIELMAN. If I might just augment that from a national perspective. What has happened is that in anticipation of the release of some more money at the end of the year, a lot of Blue Cross and Blue Shield contractors went over budget by a significant amount because they had seen the Congress working toward last year's Reconciliation Act and understood that there was a contingency fund available. The funding fact of life is that they wanted to avoid at all costs firing people, and as a result HCFA did release $15 million this year. That funding has been able to stay personnel reductions off at least for the next couple months.

Mr. BILIRAKIS. Can Senator Pepper and Mr. Fascell and I start X, Y, Z Insurance Co. and become a processor in the State of Florida?

Mr. SPIELMAN. Well the——

Mr. BILIRAKIS. You spoke of three, three Processors or three intermediaries, Prudential, Aetna, and Blue Cross/Blue Shield. Can we add a fourth if we wanted to?

Would we qualify; what does it take to be qualified?

Mr. SPIELMAN. Well, there is a whole host of detailed requirements. When HCFA replaces contractors, for example, in the State of Connecticut right now they are trying to find a replacement contractor. I think a key element of that selection process is experience. You do not want to get a company in there that is not experienced in the——

Mr. BILIRAKIS. Well, I appreciate that. Who makes that decision?

Mr. SPIELMAN. The Health Care Financing Administration makes that decision.

Mr. BILIRAKIS. HCFA makes that decision?

Mr. SPIELMAN. Yes, I think there are 91 intermediaries and carriers nationwide, but HCFA decides who gets the contract.

Mr. BILIRAKIS. Can we assume that a heck of a lot more than 91 apply to become intermediaries and the rest of them were——

Mr. SPIELMAN. No, I do not think there are people waiting in the wings overall. There have been places where the contractor has been replaced, in which case other companies might apply for that

business. But the Medicare business is very complex, and you do not tend to get a company that has no experience in it. You get an existing contractor—for example Aetna might want to move to another area—but you do not get inexperienced contractors wanting to take this on. Where they have, as it happened in the State of Illinois several years ago, where we had an inexperienced noninsurance company contractor, it really created havoc.

Mr. BILIRAKIS. Is Aetna making any money by doing this?

Mr. GRATHWOHL. No, sir. most contractors are on a cost-reimbursed basis only.

Mr. BILIRAKIS. Strictly, no fee? No fee at all, just strictly cost reimbursement?

Mr. GRATHWOHL. The [HCFA] are making some incentive-type experimental contracts, but on the whole, the contractor is reimbursed on their audited costs.

Mr. BILIRAKIS. Why is it you are in this business then; because you want to service the senior citizens of the United States of America?

Mr. GRATHWOHL. Yes, we are a large insurance company, and we have the experience, and we think that we can do the job better than anyone.

Mr. BILIRAKIS. So you are doing it out of service?

I am not being facetious, I mean, if that is the answer, then fine. I am learning something, and that is what this hearing is all about.

Mr. GRATHWOHL. That is the truth. We are a large insurance company. We are the largest group health insurance insuror in the country, and we need to put that experience to use to help administer this tough program.

Mr. BILIRAKIS. And the cost to the taxpayers—the cost to the Medicare funds, the Medicare trust fund, I should say, really which is the taxpayers, but in any case—and the cost is less than it would be if it were administered by the Federal Government?

Mr. GRATHWOHL. I am certain of that.

Mr. BILIRAKIS. Tremendously less?

Mr. GRATHWOHL. Yes.

Mr. BILIRAKIS. You are performing quite a service is what we are saving here. You are performing quite a service for the Medicare trust fund as well as more directly to the retirees, the Medicare recipients. Is that correct?

Mr. GRATHWOHL. That is right, Mr. Bilirakis, yes.

Mr. BILIRAKIS. I have something on a specific situation that might be more appropriate for HCFA later on, and I guess I will save it. It is the case that we talked about, I think we talked with your people about it in Clearwater, a particular nursing home there.

Mr. GRATHWOHL. All right.

Mr. BILIRAKIS. Is it best that I reserve that?

Mr. GRATHWOHL. Yes, sir. I think it would be good to reserve that for——

Mr. BILIRAKIS. OK, thank you. Thank you, Mr. Chairman.

Mr. PEPPER. Thank you very much——

Mr. FASCELL. Mr. Chairman, before you dismiss this panel, could I inquire regarding some other items.

Mr. PEPPER. Sure.

Mr. FASCELL. I am curious about some of the complaints which I hear constantly. I am sure we all hear them. You have doctors, hospitals, and other providers involved and a single beneficiary, and you might have two or three processors involved. We are talking paperwork galore.

Question: What can we do, all of us, to help solve the paperwork problem?

Doctors that do not want to take assignments, aside from the delays, have one person assigned in the office practically full time to fill out forms for patients. I cannot even read the form myself and I just wonder, if you are not quite healthy and you are trying to fill out a form—what are the statistics on resubmission requirements where the individual beneficiary is filling out the form and sending it in?

How much delay is involved in that?

What can we do about the forms?

With hospitals, I would expect, you have very little difficult with respect to resubmission, assuming you can read the printout on the computer. I assume what they do is just simply attach the computer printout to the form, but that is not true for the individual, so that is the nature of my question here.

What is the situation; what can we do that is better?

How can we simplify for the beneficiary, the individual who has to fill out the form?

Mr. SPIELMAN. Let me respond generally, from a national perspective. My colleagues on the panel may have their own suggestions.

I think you put your finger, in your very first remarks, on the significant problem of having to deal in one spell of illness with multiple processors. There has been a trend in this area that we are concerned about. HCFA has moved toward specialized intermediaries for certain types of claims. Boutique intermediaries, so to speak.

They have done that for home health. They have done that for parenteral nutrition, and this creates a confused situation for beneficiaries. We counted up——

Mr. FASCELL. Excuse me, let me stop you. I can understand that, but as the patient what I want to do is just fill out one form, and I do not want to have to send it back nine times. I do not want to have to deal with four providers and hospitals and doctors and equipment manufacturers. Why can't I just fill out one form, send it in, and you process it?

Mr. SPIELMAN. That is a good suggestion. I cannot argue with that. I mean I have enough trouble with my own forms.

I think that the claims processing technicians could probably give you reasons why multiple forms are needed. I think one way, one small way, to get at this is to recognize that is we have not invested enough in helping beneficiaries understand how to fill the claims forms out and in helping providers understand the complex Medicare Program, which every year, as you know, undergoes a complex set of changes.

We have under funded that critical education process. There is really no investment in Medicare on active efforts, outreach efforts,

to explain the program. We certainly send things in the mail and what have you. I think that is a significant problem.

Maybe we cannot get to one form, but we certainly should be able to explain to people how to complete the forms.

Mr. FASCELL. I think that would be helpful, but, let me tell you, I think you are biting off a big bunch. You are talking about millions of people, different languages, and all kinds of problems. I know in my own case, you read something one day and it reads this way. You read it the next day, and you wonder why you read it the way you did the first day. You have all kinds of problems. Education is important, and you need to get the material out, but I think some way, somehow, we have to bring it all together somewhere administratively. That is the way it begins to appear to me.

I am not wedded to any of this, but if I have to file under part A with processor A; and I have to file under part B with processor B; and I am dealing with four different providers, all of which have to have separate forms for their particular service, somewhere administratively we need to get that all together so that, as the beneficiary, all I do is file a claim, one claim. Now, how you spread that out administratively between processors, providers, and payers, I do not know, but that is where we need to go.

Mr. SPIELMAN. I think what we have talked about earlier in terms of what can we do to increase the assignment rate so that the providers are filing the claims. Right now, for example, you do not have to file a hospital claim. The hospital files it for you. That is the way Medicare is structured.

Now, if through prompt payment and other things, we can increase that assignment rate, it would reduce the claims filing burden or beneficiaries. The ideal world is it would not be one form, it would be no form.

Mr. FASCELL. No, I understand, but you have to include the administrative cost in that case for the provider processing or initiating. To be fair about it, you cannot put that burden on the provider without paying him for it. Right now, that is absorbed and passed on in hospital costs, or if the doctor is doing it, it has to be passed on in his fee. He cannot just eat that.

Mr. SPIELMAN. That is right.

Mr. FASCELL. We have to take that into consideration in the fee structure. If we do that and they are willing, it is OK. When they are not willing, there is a real problem.

Mr. SPIELMAN. Yes, and certainly the delay in payments and having to get loans to finance current operating expenses does not help that matter one bit.

Mr. FASCELL. No, it does not help the beneficiary either.

Mr. FASCELL. Thank you, Mr. Chairman.

Mr. PEPPER. Yes, thank you, Mr. Fascell.

Gentlemen and lady, we thank you very much for an important contribution.

Now remember, I asked you if you would send me and the other two members who are here with me today your own statement as to how much the appropriation should be and when it should be made available.

Thank you very much.

63-455 O—86——4

We have one additional witness now to be heard, and a very important one, Mr. George Holland, Administrator, Health Care Financing Administration, region IV, Atlanta, GA. We are very pleased to have Mr. Holland here. He will be a very important witness because he will be speaking for HCFA, and the Government of the United States.

Mr. Holland, are you accompanied by someone?

Mr. HOLLAND. Yes, I am accompanied by Mr. Morris, who is our director of program operations and handles the Medicare Program.

Mr. PEPPER. What is his first name?

Mr. MORRIS. Richard Morris, sir.

Mr. PEPPER. Mr. Richard Morris, very well.

You may proceed, Mr. Holland.

STATEMENT OF GEORGE HOLLAND, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, REGION IV, ATLANTA, GEORGIA, ACCOMPANIED BY MR. RICHARD MORRIS, DIRECTOR OF PROGRAM OPERATIONS

Mr. HOLLAND. Thank you. I have a prepared statement and quite a bit of background in it, and, if I could, perhaps I should cut to the heart of the matter and go to page 3, which is the contractor payment cycle and get right into the problem.

A lot of this has been brought up in parts of testimony, but this will be the complete position of HCFA in this matter.

At my office in Atlanta, we are responsible for monitoring the contracts of the intermediaries and carriers in this region. We have seen the increase in the payment cycle and the resulting rise in complaints from beneficiaries and providers.

Just last month, I testified on this same issue at a field hearing held by Senator Chiles in Jacksonville. At that hearing I indicated that the new HCFA management team, headed up by Dr. William Roper, was reviewing the payment situation immediately.

What Dr. Roper determined was that although, on average, claims are being processed in less than 30 days nationally, payment time had increased beyond 30 days for a number of contractors, including Florida Blue Shield. In addition there were projections that the payment cycle would increase to 35 and 36 days by the end of the fiscal year 1986.

Because of his concern over these projections and in order to correct the unevenness in timeliness of payments, Dr. Roper recently released additional funds to assist the contractors in approaching a 27 days payment cycle.

I should note that in the past 7 weeks we have provided additional moneys for claims processing to our contractors in Florida. On May 26, we released $700,000 to Florida Blue Shield and again on June 16, with the availability of the contingency fund, we provided an additional $852,200 to Florida Blue Shield for B claims and $301,500 to Florida Blue Cross for A.

We understand that these additional funds allowed Florida Blue Shield to hire additional staff to start reducing the claims backlog.

Before I elaborate on our new instructions to the contractors regarding the payment cycle, I want to discuss the reasons why payment time lengthened.

Our initial request for the Medicare contract for this fiscal year was tight, but we thought adequate to do the job, given our best projections of Medicare claims volume and associated costs.

Our appropriation request to Congress last year assumed that nationally the contractors would process 61.1 million claims under A and 282.4 million claims under 8. This represented an increase in workload of 6.8 and 10.5 percent, respectively. However, we currently estimate that we will receive an additional 2.9 million claims under part A and 17.9 million claims under part B.

This increase in workload above our initial projections is caused by a number of factors, the most significant being a dramatic increase in claims for both outpatient services and lab billings. The increase in claims for outpatient services appears to be the effect of the relatively new perspective payment system for Medicare, and the increased lab claims result from the direct billing provision of the Direct Deficit Budget Act of 1984.

In addition to the budget, there are two other factors that led to the problem:

Consistent with developments throughout the health care market and the necessity to ensure that trust fund dollars are spent appropriately, there is an increased concern in the Medicare Program about medical review and third party liability. New medical necessity reviews and efforts to identify situations and collect payment when Medicare is not the primary payer require additional claims processing time, particularly in cases where the provider has not accurately submitted the claim.

Our contractors will process over 360 million claims in fiscal year 1986 from over 17,000 institutions, 450,000 physicians, 75,000 suppliers, and 31 million beneficiaries. Consequently, operational problems impacting a relatively small percentage of claims in a system this large will affect a substantial number of providers and beneficiaries. A recent example of this type of problem is the slowdown in payment to home health agencies resulting from the introduction of a new medical review form.

Now, the 27 day payment cycle which was mentioned earlier—the increase in Medicare payment time has generated proposals for putting a payment cycle in statute and for making the Federal Government pay interest when a claim is not paid within a given timeframe. We do not believe that this is necessary or desirable.

To elaborate on my earlier remark, we are committed to a payment cycle that is reasonable and that will serve to reduce and eventually eliminate the uncertainty about payment time that has existed previously.

We have directed our contractors to process 95 percent of all so-called clean claims within 27 days. This means we will pay essentially each and every clean claim in that timeframe. By clean claims, we mean claims that can be processed upon receipt and that do not require further development and/or correction. We estimate that roughly 70 percent of all Medicare claims are clean.

Although we are committed to paying clean claims in approximately 27 days, there are significant operational issues concerning the 30 percent of claims that require further development. These issues argue against a statutory payment cycle for all claims and interest penalties. In addition, the sheer magnitude of the volume

of these claims and our commitment to development appropriate timeliness standards argues against the imposition of cumbersome and costly administrative systems to provide notice about processing delays.

Roughly 30 percent of all Medicare claims require further development for a number of reasons. The claim may be missing information or otherwise not completed properly. The claim may also require development for reasons I mentioned earlier having to do with either medical necessity review or third party liability.

Contractor medical review activities saved the Medicare Program $590 million in fiscal year 1985. Each medical review screen addresses a particular utilization problem that has been experienced in the program. Based on the criteria of the screen, individual claims are identified through computer edits for further review by contractor medical personnel.

An example of one of these is our mandated screen for prosthetic lenses. This resulted from a 1985 General Accounting Office review which determined that inadequate guidance to the contractors led to unnecessary expenditures for these lenses. The GAO recommended that a uniform screen be implemented by the contractors to identify claims for additional replacement lens beyond one per year.

Following the recommendation, carriers now screen claims beyond one replacement lens per eye per year. Claims that are caught by computer edits are then reviewed by the contractor medical staff, and normally this requires a request to the provider to submit additional information to justify the medical necessity of the claim. Once it is received and reviewed, a determination is made as to whether the claim can be paid. Although this process assures that program dollars are spent for medically necessary services, it does result in claims being paid beyond the normal processing time for clean claims.

Initiatives in the area of third party liability produced program savings of $750 million in 1985. These initiatives include review of claims from the so-called working aged, that is, individuals who are either still employed and receiving health benefits through work or the spouse of an employed individual who has health insurance coverage.

In a similar effort, we look for private insurance coverage for individuals with end-stage renal disease during their first 12 months on maintenance dialysis.

The other areas of potential third party liability are where liability insurance or workmen's compensation cover a beneficiary's medical expenses resulting from an accident.

Clearly, when claims are determined to involve the potential for third party liability, payment, if any, from the program is delayed.

Although we do not feel that a 27 days timeframe is possible for the 30 percent of other claims that I mentioned above, with further development, we are committed to developing appropriate standards for these type of claims; and these are mainly the claims you heard about this morning.

Our goal is to reduce the uncertainty facing providers, physicians, suppliers, and beneficiaries in regard to the amount of time they must wait to be paid. Given this commitment, we do not feel

that it is necessary to require that a notice be provided to individuals or entities submitting these claims that their payment will be delayed beyond the normal payment cycle for clean claims.

In order for the Medicare Program to function properly, we have to maintain the trust of our beneficiaries, providers, physicians, and suppliers; and one of the elements of this trust is the knowledge that payment for services will be predictable and reliable.

We have taken action toward this goal by implementing a payment cycle for "clean" claims of about 27 days. Program safeguards will continue to result in our contractors taking longer to process certain type of claims, but even with these, we are committed to developing appropriate standards. We believe that our actions will assure the continued confidence of the public in the Medicare program.

I believe one of the gentlemen from the plan mentioned earlier that the standard on those 30 percent other claims, the ones that go into utilization review, would probably come out at about 60 days. Up until now, there has not been a standard, and it has caused real havoc in the industry.

[The remainder of the prepared statement of Mr. Holland follows:]

PREPARED STATEMENT OF GEORGE HOLLAND

My name is George Holland and I am the Regional Administrator of the Health Care Financing Administration (HCFA) for Region IV. I am accompanied by Dick Morris, the Director of Program Operations for the Region. I am pleased to be here today to discuss my Agency's role in administering the Medicare program, in particular, the issue of the timeliness of program payments.

BACKGROUND

Before I discuss this issue, I would like to provide a brief overview of the Medicare contractor program. In 1965, when Medicare was enacted, Congress adopted an administrative structure which was compatible with the existing practice within the private health insurance industry. As a result, the Federal Government contracts with private sector organizations to process payment to providers, physicians, suppliers and beneficiaries. These organizations are known as intermediaries under part A, the hospital insurance portion of Medicare, and carriers under part B, the supplementary medical insurance portion.

At present there are 91 contractors in the Medicare program - 54 intermediaries, 36 carriers, and one combined intermediary/carrier. Under part A, hospitals and skilled nursing facilities (SNFs) are permitted to nominate a private insurer to act as their intermediary. Home health agenices (HHAs), on the other hand, are assigned by HCFA to regional intermediaries. Claims for services rendered under part A are reimbursed by intermediaries directly to providers. Under part B, private health insurance organizations are selected by the Federal government to serve as carriers for defined geographic areas. Payment can be made to either the physician, the supplier or the beneficiary, depending on whether or not the claim was accepted on assignment. Approximately 68 percent are paid to physicians and suppliers and about 32 percent are paid directly to beneficiaries.

In addition to processing claims and making payments, intermediaries and carriers review the medical necessity of claims submitted, identify situations and collect payments where Medicare is not the primary

payer, and recover overpayments when it is determined that an incorrect payment has been made. Finally, both intermediaries and carriers provide information and guidance to beneficiaries, providers, physicians and suppliers on coverage and payment issues.

For the most part, carriers and intermediaries are reimbursed for their costs subject to standards established by HCFA. Federal funding for Medicare contractors has increased from $93 million in 1967 to $1.0 billion now requested for 1987. Total administrative costs of both HCFA and the contractors is now approximately 1.6 percent of total program costs. The ratio of administrative costs to total costs is better than that of the majority of organizations providing health insurance in the private sector.

Here in Florida, Florida Blue Cross and Aetna are our primary intermediaries and Florida Blue Shield is our carrier. In FY 1985, these contractors processed 2.8 million claims for part A and 18.8 million claims for Part B. This represents 4.8 and 7.1 percent of the total claims processed nationally for part A and part B, respectively.
I would be remiss if I did not mention here that Florida Blue Cross received the highest ranking as a part A itermediary in the nation in the FY 1985 contract performace evaluation. We are proud of their achievement and of the significant improvement they made from the previous year. Florida Blue Shield also made significant gains in performance during the past year and we hope that additional progress can be achieved in the current year.

Mr. PEPPER. Thank you very much Mr. Holland.

Does your associate wish to make a statement?

Mr. MORRIS. No, I do not believe so; not at this time.

Mr. PEPPER. Mr. Holland, I do not see in your statement or hear from your statement anything about the HCFA or the Government making a conscious decision to delay, purposefully to delay, the payment of claims so that the money that would be used in the payment of claims can derive interest in the trust fund.

Mr. HOLLAND. Right.

Mr. PEPPER. Did you intentionally leave that out, or is that a false statement?

Mr. HOLLAND. No, we very intentionally changed that. Prior to the Senator Chiles hearing that I attended in Jacksonville, a decision was made by the new management team under Dr. Roper to drop that policy. That is not the policy of HCFA. We have moved away from the trust fund and a 30-day payment cycle, completely changed the system.

Mr. PEPPER. It was—now I wrote a letter——

Mr. HOLLAND. It was the policy——

Mr. PEPPER. I wrote a letter to the Secretary of Health and Human Services on May 1, and it was put in the record here this morning, calling attention to that very fact. Now, you say that it was at one time it was a policy of the Government intentionally to delay the payment of claims?

Mr. HOLLAND. Yes, it was.

Mr. PEPPER. Well, aren't you ashamed of it?

Mr. HOLLAND. We did not like it that much nor did Dr. Roper.

Mr. PEPPER. Well why did you do it?

Mr. HOLLAND. It was the decision of the HCFA Agency for a very short time prior to Dr. Roper coming in and changing it to go that direction. The reason they did it I do not think was primarily to save interest for HCFA, after they received their appropriation it was cut $41 million by Gramm-Rudman and then additionally we were hung up on the continuing resolution until February, and we had another $15 million hung up in OMB. So we were down to $920 million when our appropriation was $978 million, and we were in trouble, and that, of course, is——

Mr. PEPPER. Who was responsible for the size of that appropriation?

Mr. HOLLAND. HCFA requested $978 million, but Gramm-Rudman cut us $41 million and OMB had $15 million, and we were in trouble and down to $920 million, and that is when they had to come up with some policy, and they decided to do that.

Mr. PEPPER. Have you made an appropriation for administrative expenses for the year 1987 fiscal?

Mr. HOLLAND. Yes, sir, we have.

Mr. PEPPER. How much did you recommend?

Mr. HOLLAND. We recommended $1 billion $70 million.

Mr. PEPPER. Do you think that will adequately provide prompt payment of the claims due to the providers and the beneficiaries?

Mr. HOLLAND. We think it will. The contractors disagree with that position.

Mr. PEPPER. Well, they are pretty good judges, aren't they?

They are closer to it than you are.

Mr. HOLLAND. We are pretty close to it. What we did last year, which was our mistake, is that we completely missed on our estimates. In other words, we fund the contractor on——

Mr. PEPPER. Well, your last request for appropriation was grossly inadequate, wasn't it?

Mr. HOLLAND. Right, yes, sir.

Mr. PEPPER. Well, are you trying to correct it now?

Mr. HOLLAND. We are trying to correct it by raising that from $978 million to $1 billion $70 million.

Mr. PEPPER. After all, this is not your money, is it?

Mr. HOLLAND. No, sir.

Mr. PEPPER. It was paid in by the people of this country, that is, those covered by the broad Social Security Program, the workers and the employers of those workers of this country. Now then, it is the intention of the Congress that this program be efficiently administered, and you do not seem to be administering it efficiently. You are trying to niggardly save money at the expense of the providers and the beneficiaries of this country. Why are you trying to do that?

Mr. HOLLAND. Sir, I do not think we are doing that.

Mr. PEPPER. Well that is what the record shows.

Mr. HOLLAND. The beneficiaries are a very real concern of ours, too, and we feel that with the increase in 1987, we will be able to cover it this time. We admit our mistake last year.

Mr. PEPPER. Doesn't the administrative expense come out of the gross Social Security Fund?

Mr. HOLLAND. Yes, sir; it does.

Mr. PEPPER. Well, why do not you use it adequately to accomplish the purposes of the fund?

Mr. HOLLAND. We hope that that will happen in 1987. We missed in 1986.

Mr. PEPPER. Well, it looks to me like everything you try to do is niggardly, trying to hold back and one time you deliberately entered a policy of holding up the payments while the money was out at interest.

Now we are going to take some more circumspection and look at your recommendations, and if you have not recommended enough, you are going to hear from Congress about it, I can assure you of that.

Mr. HOLLAND. Thank you, sir.

Mr. PEPPER. And you better review because we want these back claims paid, and it is not your money. It is the people's money. They are entitled to it. You are not getting it to them as they are entitled to get it, and you have been culpable, in my opinion, to a disgraceful degree. I hate to say it, but I think it is the truth, and I feel that way very deeply. We should not have to push you to get you to do what ought to be done. Why don't you take the lead in doing what ought to be done, telling us you need more money?

And if we do not get it to you, then it is our fault, but if you do not ask for it, it is not our fault, it is yours.

Now you are telling us here today that you think you requested enough money for fiscal 1987.

Mr. HOLLAND. Yes, sir, but there is another total factor that is a problem and that is when the money flows.

Mr. PEPPER. All right. When do you want the money to be available?

Mr. HOLLAND. At the beginning of the year so we can work out a national budget——

Mr. PEPPER. You are entitled to that. We will try to see to it that you get that.

Now, the other thing is—I do not know, of course—you made an exception here now between the claims you said that can be readily paid and the claims that need to be reexamined.

Mr. HOLLAND. Right.

Mr. PEPPER. And, you know, one of the problems of the Government is redtape. If you let anything go through the Government, the chances are that it is going to take longer to do it and cost more to do it if the Government has anything to do with it. So I do not know whether we can rely upon you to make a fair distinction between the claims that should properly be paid, promptly be paid, and the ones that require further examination. You could just use that as an excuse for further delay, like you have been doing.

Mr. HOLLAND. No, sir; the contractors do that, and they have regular formats and edits just like IRS has, where a claim seems to be out of line, it will come out of the edit, and they will examine it manually.

Mr. PEPPER. I made the suggestion here earlier—you may have heard it—that in respect to, for example, hospital care that under this DRG enigma that we have—I hope it will go out the window at an early date—that there be, for example, a doctor in every hospital that will pass on the matter of whether a patient should be turned out under an arbitrary formula or whether that patient should be allowed to stay 1 more, 2, 3, or 4 more days, whatever the good medical advice should require.

As it is now, we have got that DRG, that is the automatic formula, where the hospital is paid according to the disease and not according to how long really the patient should be in the hospital, so the claim is being made all over the country that people are being pushed out before they are medically ready to be pushed out of the hospital.

Rather than having an automatic formula like that DRG thing that we have now, would you think it would be feasible to have a doctor, who would be the representative of both the recipient and the Government, to pass judgment on whether a patient should be turned out of the hospital at a certain time or not?

Mr. HOLLAND. I have heard that approach taken earlier. It sounds like a good idea, although we have a system where doctors review those claims, and contrary to what a lot of people think in the country, if, in fact, it is a severe case of pneumonia, there is a thing called an "outlier." Say that the pneumonia DRG is 7 days, if the outlier kicks in, that person can stay in the hospital until the doctor says they are ready to get out, so it is not that abrupt.

The other thing is that we found the same thing you did in the last 2 months, and every hospital in this country now must read and hand to each patient their rights, that they cannot be removed from a hospital, that they have a review process that they can utilize, and the hospital will adhere to it, or they will not stay in the program.

In addition to that, we have a pro review with a separate organization of doctors coming in and looking at those patients with surveys to see if, in fact, there is any early discharges. So, we, too, are concerned about——

Mr. PEPPER. You have doctors coming in?

Mr. HOLLAND. We have under the peer review organizations, doctors and nurses coming into the hospitals and pulling records to make sure that we are not ending up with premature discharges.

Mr. PEPPER. Would it not be cheaper to have one doctor that would be stationed in and serve that function in the hospital and for the hospital?

Mr. HOLLAND. If you could keep his impartiality; if he is connected with the hospital, that might be a problem.

Mr. PEPPER. One thing that I would emphasize to you people in HCFA is, do you realize that you are dealing with people who live—about half of the elderly people of this country rely for half of their total income upon their Social Security for their income.

Mr. HOLLAND. So do my parents.

Mr. PEPPER. Well, you understand.

Take your parents as an example. Suppose they had a serious illness and the doctors did not take assignment and they had to go pay the doctor's bill. Maybe with your ability to help them, maybe you would aid them, but if your parents had to rely upon only their Social Security, do you realize how embarrassed they would be if they could not get reimbursement at a reasonably early date for what they had to pay out to the doctor?

Mr. HOLLAND. I think they would be extremely embarrassed, and they would go into debt rather than miss that payment.

Mr. PEPPER. What I am emphasizing is that yours is a tendency that somehow inevitably becomes involved in governmental decisions. That is the reason the people complain so often that Government takes too long to do it, and does not do it as efficiently generally as private enterprise would, but the Government gets the point of view of the OMB.

You are thinking more about the statistics of it, the accounting aspects of it, and maybe saving against some possible wrong somewhere, but you forget about the fact that you are dealing primarily with a lot of dependent people to whom a little money means a lot; and delay in payment to them of even a little money is very serious; and I wish we could feel that you people in HCFA are thinking primarily of the people you duty it is to serve, the elderly people of this country who get sick. They need help. They are not getting enough now.

Medicare is only paying 48 percent, according to the figures we have of the medical costs of the elderly today. If an elderly person gets Alzheimer's disease, they do not get any help from Medicare, and for many other of the costly diseases, they do not get any help.

If they need transplants, there is a limited amount of aid available to them, but not enough, so we have got to do something in this country to revise this system that we now have to make it more operated by private enterprise, more efficient in administration, the way the Chrysler Motor Co. has made its health program, as I understand it, under the recommendations of former HEW Secretary Joe Califano—a program under which every man,

woman, and child in American can get the medical care that he or she should have. We have not got that kind of a system now, have we?

Mr. HOLLAND. There are many problems with the system, I agree.

Mr. PEPPER. And so, it seems to me that in a country like ours, we ought to make some provision in the American way, to create some sort of an insurance program that allows every man, woman, and child in America to live as long as medical science and facilities can enable that individual to live.

Life is a divine gift, and it cannot be supplemented in any other way. The medical skill and the facilities ought not to be lent just to those who have money in America. We have done the best we could so far by setting up this Medicare system, and I just hope you will administer this program with a new point of view. Our job is primarily to serve the elderly people of this country and to think less about delaying payment so as to make a little more interest or this, that, or the other.

I have spoken strongly because I feel strongly about this matter, and I hope when you make another recommendation to the Congress you remember that the money that you are requesting for this administrative expense is in this program, is in the trust fund. It is there for that purpose, and if you make a mistake, you are doing a grave injustice to millions of your fellow Americans, maybe to your mother and father. It is unfortunate if misfortune should strike them.

So, we are going to take a much stronger and closer look at this matter than we have in the past, and I hope you all will go back and reexamine what you recommended for 1987, and if you are not sure that it is going to provide enough money administratively through these intermediaries to do what the people of this country are entitled to have done, you revise your amount, and you recommend more. That is in the trust fund and that the people are entitled to get.

Mr. HOLLAND. We will do that.

Mr. PEPPER. Thank you.

Mr. Fascell.

Mr. FASCELL. Thank you, Mr. Chairman.

Let me add my commendation to the change in policy and ask you what your estimate is and how long it will take to clean the backlog.

Mr. HOLLAND. The backlog in Blue Cross/Blue Shield will run now what?

Mr. MORRIS. By the end of this fiscal year, which will be September 30 in Blue Shield, Blue Shield projects, based on the additional funding we have provided, their backlogs will be down from 1.7 million down to 900,000 claims, which is 400,000 claims greater than the backlog was as of September 30 last year.

Mr. FASCELL. It sounds like your criteria is a normal backlog.

Mr. MORRIS. There is generally a normal backlog at the end of every month. There has been every day since the beginning of the program. However, that backlog——

Mr. FASCELL. That is predicated on a 27-day turnaround?

Mr. MORRIS. No, that backlog is—there has always been a backlog. You cannot process all your claims each month, whether it be Medicare, Medicaid, or private insurance business. There is always a volume of pending claims at the end of the month. That volume has increased substantially in almost every contractor in our country this year because of our unanticipated growth in claims receipts.

Mr. FASCELL. And part of that was policy, and part of it was program?

Mr. MORRIS. Well, at the beginning of the year, we had an appropriation. As Mr. Holland mentioned, there was a reduction in that appropriation. We had a contingency fund of $15 million being held by the executive Office of Management and Budget. We went to them in February to get that money to put into claims processing. We did not receive it until the last of May, and we now have that money out in the contractor's shop. Had we been able to get it out earlier, we would not have been forced into the position that we were.

Mr. HOLLAND. I think the——

Mr. FASCELL. I——

Mr. HOLLAND. I am sorry.

Mr. FASCELL. No, that is all right. Go ahead, Mr. Holland.

Mr. HOLLAND. I think the policy that Congressman Pepper is upset about was driven by us being down to $920 million instead of our appropriated $978 million, and as soon as we got relief on that, I am very glad that Dr. Roper changed that.

Mr. FASCELL. Well, let's examine that for a moment, OK?

Administrative costs for the program are the responsibility of HCFA——

Mr. HOLLAND. That is right.

Mr. FASCELL [continuing]. As the agency for the U.S. Government. The money is in the trust fund. Now, why do you have to go through that process? If you need additional money, why don't you just take the additional money, make it available?

Mr. MORRIS. We have to follow the appropriation process in order to get money from the trust funds, too.

Mr. HOLLAND. We cannot contract the budgets.

Mr. FASCELL. I just wanted to be sure you could still play football. I threw you an inflated football, and I wanted to see how far you could run with it.

So, what you are saying is Congress has to appropriate the money, even though the money is in the trust fund.

Mr. MORRIS. Yes, sir.

Mr. FASCELL. And if you make a misjudgment or OMB makes a misjudgment, then we are stuck with it.

Mr. MORRIS. Yes, sir, and we are stuck with it, and the public is stuck with it.

Mr. FASCELL. In other words, if you guess too low on the amount of money you need for administration, and Congress provides every dollar of it, but it is still too low, then the beneficiaries suffer.

Mr. MORRIS. That is true.

Mr. FASCELL. So why would you ever gamble on being too low?

Mr. HOLLAND. We did not think we were in 1986.

Mr. FASCELL. No, I understand.

Mr. HOLLAND. All right.

Mr. FASCELL. The money is there for administrative purposes. The worst that could possibly happen is that you lose interest on the money that is in the fund. But even then, that is not the case because the situation is that you do not draw the money down until you spend it, so the money stays in the fund anyway. Is that correct?

Mr. HOLLAND. Correct.

Mr. MORRIS. That is correct.

Mr. FASCELL. So, what do you do; do you draw down quarterly?

Mr. MORRIS. Intermediaries, contractors, as I recall, sir, draw down monthly on their administrative costs.

Mr. FASCELL. How does HCFA pay; do you pay monthly?

Mr. MORRIS. They have an account on which they draw their administrative costs.

Mr. FASCELL. Well, do you adjust on a quarterly basis?

How do you have any budgetary control?

Mr. MORRIS. At the beginning of the year, generally, the contractor is given a number of dollars to process claims and to——

Mr. FASCELL. In other words, HCFA allocates a number of dollars going to a specific provider?

Mr. MORRIS [continuing]. To a specific contractor.

Mr. FASCELL. Contractor, I am sorry.

Mr. MORRIS. Yes.

Mr. FASCELL. Processor——

Mr. MORRIS [continuing]. Which is a little bit of a change, departure, from our process in the past. In the past we had negotiated budgets. There have been some negotiations in the past couple of years but because of the funding availability and the decision to handle things a little differently, the contractors were given *x* number of dollars to handle their functions.

They gave us a plan of expenditures; that is, a plan on how they would spend that money over the year, and we monitored their expenditures of those funds each quarter and in some cases on a monthly basis.

Mr. FASCELL. What I am trying to get at is, since you have made the decision with respect to the monitoring of administration and you have made a decision with respect to allocation without arm's length contracting, which is what I understand you are doing, the question is, How does a processor adjust?

Can he come to you at the end of the first quarter and say, "Hey, you made a mistake?"

Mr. MORRIS. Yes, sir. There are provisions in our contract with them. If the contractor feels there is not sufficient money in his budget to process claims, and he is going to have to cut back on an activity, then there is a process whereby they notify us 60 days prior to the expenditure, the point at which they will no longer have funds, that they are going to have to abate, or in effect stop doing a function.

Mr. FASCELL. Well, Mr. Morris, that evidently did not work.

Mr. HOLLAND. Well, the problem was they sent in the abatement letters, but we did not have the money, and that is when they had, as I indicated earlier, that is when they had to set up a policy to say how——

Mr. FASCELL. We knew that going in, Mr. Holland.

Mr. HOLLAND. We did not. We made a bad estimate, and I can tell you that the estimation branch or section or whatever has changed drastically, and there is going to be a new process in 1987.

Mr. FASCELL. Well, do you think that it might be better to get back to negotiating with the processors?

Mr. HOLLAND. That is also under consideration.

Mr. FASCELL. And do you think that part of that will be a mandatory review on a quarterly basis?

Mr. HOLLAND. Oh, yes.

Mr. FASCELL. Sixty days notice is two-thirds of a quarter, so you might as well mandate automatic review of the processing administration.

Mr. HOLLAND. What actually happens with the close contact between our office and the contractors, we know 15 days after they have got a problem.

Mr. MORRIS. Generally that 60-day period does not come until the end of the fiscal year.

Mr. FASCELL. Thank you.

Mr. PEPPER. I do not want to interrupt. I just want the record to show that one of our distinguished colleagues, the Honorable Larry Smith, has been with us. He has to leave now before he has an opportunity for questioning but we want to thank him for coming and——

Mr. FASCELL. I will be glad to yield him my time.

Mr. SMITH. I am not sure I want to get started on them.

Mr. PEPPER. He is a good friend of the elderly, and we knew he would be here. We are glad you came.

Mr. SMITH. Today is my day with the kids on buckle up for safety board. I appreciate what you are doing. It is a very important issue to the people who are on Medicare.

Mr. PEPPER. Thank you very much.

Mr. FASCELL. Be sure and wear your buckle.

Mr. SMITH. Absolutely.

Mr. PEPPER. Go right ahead. Have you finished, Dante?

Mr. FASCELL. I am finished, Mr. Chairman. I think they understand what my concerns are.

One final thought is that HCFA has a responsibility also with respect to ease and simplicity of administration. It would be very useful, it seems to me, if the leadership was exercised so that everybody involved in the program could give it some consideration.

I certainly have no particular desire to design a program, but I do know from practical experience that it is extremely difficult right now. I understand that there has to be some burden on the beneficiary to be able to comply with the program. Having said that, however, I can tell you that if you have ever been involved personally or any member of your family has been involved, you are up to your chin in paperwork. You are never sure exactly who got what, what got paid with which, and when you got through, whether it was all paid or whether you owe anything.

It is a very complex process, and I think beneficiaries are on the bottom end of that. Anything that we could do that would simplify the process would be extremely beneficial.

Mr. PEPPER. Thank you very much, Mr. Fascell.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

You do not need any more criticism. You do not need any more preaching, but I think it is just important that we realize that as a result of the way we have been conducting the system, we have been discouraging, for instance, assignment. The sort of thing that we really want to see happen is not—on a volunteer basis, I should say, not mandated—is not happening, and we have heard some of the reasons. I know you gentlemen were in here all through the hearing, and so you heard some of these reasons from the actual people who are providing the service. And so it is just critical that we try to clear up and improve the areas that need to be improved, and God knows there are many of them, as there would be with any complex situation.

The companies that are in bankruptcies, the firm of 22 physicians which accepted assignment 100 percent has now gone out of businesss in that capacity. I mean, this is just a wrong thing that we are really doing. Why does the Government—am not going to go into whether that $300,000 approximately that is owed them, they feel at least is owed them, is within the 30-percent figure that you mentioned, Mr. Holland or whether some of it was, in fact, in the "clean" category, and there is no excuse for it, and $800,000 that affected that one other company to go into Chapter 11.

I will maybe follow through with Mr. Fascell's questioning though, after all, he certainly has a lot of experience in these areas, and when we go into this area, it is about as complex as foreign affairs, if not more so.

Do you agree that considerably more savings result from using the intermediaries?

Mr. HOLLAND. Definitely.

Mr BILIRAKIS. Definitely; they are much more efficient, right?

Mr. HOLLAND. We did not get into that, but we used to have an outfit in HCFA that processed claims, and we took a look at costs, and there is no comparison in either costs or efficiency.

Mr. BILIRAKIS. OK, then do you audit—Mr. Fascell sort of mentioned this—do you audit or review the costs incurred by the contractors since we reimburse them their costs; they do not make any profit?

You do audit them, right?

Mr. HOLLAND. We do regular cost audits. We have a very stringent system called "CPEP," and it measures all elements, and they are rated at the end of every year, like a report card.

Mr. BILIRAKIS. So you have a level of confidence, a high level of confidence, in their functioning?

Mr. HOLLAND. Definitely.

Mr. BILIRAKIS. And in their determination of costs.

Well now, Mr. Holland, I do not mean to put you in a spot, you do not make these decisions, but why then, if I have that high level of confidence in these people, do we not go along with their suggestions, their recommendations, as to the total dollars that it takes administratively in order to take care of this backlog?

Mr. HOLLAND. Well with a contractor, or like any business, their projections and ours are going to vary.

Mr. BILIRAKIS. Well but, sir, we have indicated we have a high level of confidence in what they do; we audit their costs, they are awfully efficient. All of these good things, and then we say there are differences in projections, when, in fact, they are right there on the line. They are right there with the grass roots.

Mr. HOLLAND. We are getting into an area of competition of money. In other words, the contractor is saying they are going to need this much more next year, and we, obviously, say, "I don't think you need that much." We are talking dollars——

Mr. BILIRAKIS. All right, but it comes out of the fund, and it is obviously important to control that because it lessens the fund if we increase the administrative dollars. There is no question about that, but if you audit their costs and you have an awful lot of confidence in them, even if they get more costs than you think are necessary in the process of the auditing and that sort of thing, you can determine that there probably would be an excess there, if they are doing the job that they say that they are doing, common sense, I think, and logic, isn't it; which I know does not always apply, but God knows it ought to in this case because we are hurting the Medicare concept and the assignment concept that we really want to encourage.

One last thing in the interests of time: one of my constituents has called my office complaining about rate schedule for a particular nursing center in my district. Apparently my staffer has seen, I think, has seen the rate schedule. There apparently is a printed rate schedule. A semiprivate costs per day $57, private $94, Medicare $500 per day, the Medicare reimbursement $500 per day.

Mr. MORRIS. A skilled nursing facility can charge a Medicare patient whatever the facility wants to charge, but Medicare would pay to the facility the reasonable cost of providing the services, and the patient would have no liability to the facility for the differences in those charges, except for the coinsurance amount under the Medicare Program. I cannot imagine a facility providing, a nursing home providing, services to a private pay patient for $57 and not being able to provide those same services——

Mr. BILIRAKIS. Under the law they are required to charge Medicare patients at the rate they charge private patients, are they not?

Mr. MORRIS. I do not recall that particular aspect of law. You are probably right, sir.

Mr. BILIRAKIS. That is our information, having researched it out. I am not on a witch hunt——

Mr. MORRIS. No, I understand.

Mr. BILIRAKIS [continuing]. But, by gosh, if there is any fact to this, my understanding is that there is, then small wonder our Medicare fund is being depleted if we are that darn careless, and we are trying to also encourage our people, our constituents, our Medicare patients, if you will, to review their bills—are we not—to review their bills for mistakes and things of this nature?

We now have an instance where this has been done, and I owe this lady some kind of an explanation to find out, in fact, if there is $500 being reimbursed by Medicare in an instance where a private room is $94 per day, and that, by the way, does not cover the costs of personal physician visits, medication, durable medical supplies, et cetera, et cetera.

Mr. MORRIS. If the patient is eligible for Medicare, Medicare would not pay on the basis of cost. My own mother, who is in a nursing home, after her Medicare benefits expired was being charged $5,000 a month, and that was paid, and it just destroyed her——

Mr. BILIRAKIS. Yes, but that is the same charge it would be if she were a private patient, right?

Mr. MORRIS. Yes, she was a private patient.

Mr. BILIRAKIS. All right, she was a private patient, $5,000 a month, right. But if Medicare were to reimburse, it would be $5,000 a month.

Mr. MORRIS. It would be—OK, it might be less than that.

Mr. BILIRAKIS. It might be less than that, but certainly would not be in excess.

Mr. MORRIS. Right.

Mr. BILIRAKIS. Well, this is a relatively new nursing center and that could be part of the problem, but I just cannot see $94 to $500.

Mr. MORRIS. If we do not already have that, we would love to look at that.

Mr. BILIRAKIS. OK, I assure you we will——

Mr. HOLLAND. If they continue that posture, they will not be a very old nursing home either.

Mr. BILIRAKIS. Well, but the question that I have in my mind, I am not taking shots at the nursing home, is the process. Does the law provide for this and allow it to be taking place, and if it does then——

Mr. MORRIS. I cannot. I do not think they can do that.

Mr. BILIRAKIS. Yes, I am sure you would know. Well, we will be in touch with you on this.

Mr. MORRIS. Thank you, sir.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. PEPPER. Apropos of the questions proposed by Mr. Bilirakis, this subcommittee had some hearings recently in respect to cataract operations, the new process where you go in through the eyeball and crush the lens that is in the back of the eyeball and take that out and put a new lens in, a little instrument they say costs about $50 or $75 for the company to make. It takes the doctor from 30 to 45 minutes, I understand, to do that operation.

It is something like about $2,100 that that operation costs if paid by Medicare if the patient is an inpatient in the hospital, but if the same patient is not enrolled as a patient in that particular hospital but as an outpatient in the same hospital, has the same operation by the same doctor, you all have been paying around $5,400 for that same operation. The reason is that there is a limitation today upon the expense or the cost when the patient is in the hospital, but there is apparently no legal limitation on the charge that can be made to a patient who is an outpatient in that hospital and gets that operation.

Now, don't you all have administrative authority to see to it that in that case the payments are the same, at least the patient does not have to pay more? You all do not have to pay more for the patient just because he is not enrolled in that hospital.

Don't you all have some authority to do that?

Mr. HOLLAND. Let me answer. There are two parts to this. One is after that hearing I can—in other words, we are from the Atlanta region, and we receive our direction from HCFA. After that hearing I now have, I think it is 10 staff on the phone calling hospitals back to 1967 and getting a background on those operations. They are doing that—what, all week?—to get the information back to Baltimore, I think within 7 days to address the problem. So that is what happened, and that is what we are doing.

Mr. PEPPER. We are pleased that the hearing had some beneficial effect. There is no justification for your paying—we do not want you to pay any money you are not properly required to pay. We want you to save all you can, but we want you to pay promptly the claims that ought to be paid.

Now, just one last question. Is there anything you all can properly do for these people who suffered by reason of the delinquency in receiving the payments that they have received in the past, these people that have gone bankrupt, for example?

Is there any aid you can give them properly?

Mr. HOLLAND. The only thing we could do there if the contractor is still in the room is get with those people and the contractor and address those problems individually, take a look at them.

Mr. MORRIS. I believe, too, the contractor has made to certain DME suppliers who——

Mr. PEPPER. Will you all examine the facts in these cases and see if the facts would justify your giving them any help you are authorized to give?

Mr. HOLLAND. Yes, we will.

Mr. PEPPER. You who are here, if you are still here, can arrange a meeting. You all can have a little talk about this matter afterward.

Well, gentlemen, we want to thank you very much for being here. We are all of us citizens of our great country. We just want our Government to do the best job for our people that they possibly can, and we hope that as you profited by some of these other hearings that we all may profit somewhat by this hearing today.

We appreciate the spirit in which you have come here to cooperate with us and help us because we are all trying to help the people who need the help in our country, especially the elderly.

Thank you all very much. We appreciate it.

Mr. HOLLAND. Thank you, sir.

Mr. PEPPER. I want to thank very much my colleagues, Mr. Fascell, Mr. Bilirakis, and Mr. Smith, for their coming and their valuable cooperation here today, and I wanted to thank the county commission for kindly letting us use their fine facilities here today, and I want to thank the able reporter and the media who have covered our hearing today.

The hearing is adjourned.

[Whereupon, the hearing was adjourned at 1 p.m.]

APPENDIX

July 11, 1986

I have compiled some data from the records I have on Medicare and would like to submit it at this time. This data covers the years 1984, 1985 & up to July 1986.

1984 - In 1984 I submitted 12 claims, of which 9 required no telephone inquiries, but the other 3 required 7 telephone calls and each were re-submitted for a second time. The shortest processing time for a claim in 1984 was 15 days and the longest processing time was 116 days. This was due to omitted codes not paid benefits for and also request for review.

1985 - Of the 21 claims submitted this year, 11 required no inquiries, however the other 10 required me to make 42 telephone calls for status information. These 10 claims were re-submitted 16 additional times because they could not be located and I was told to re-send them and also because of cross-filing errors. 2 claims were re-sent because of omission of payment on legimate codes and also for a review. The shortest processing time was 26 days, the longest 115 days.

1986 - Through June 23rd of this year, I have submitted 6 claims and I have called the Medicare office 13 times. I have re-sent 5 of these claims, 4 being sent for the second time and one for the third. The claims dated April 28th, May 27th and June 23rd are still PENDING. I called July 8th for a status on the April 28th claim and was told it is not on the Computer yet, call back next week, if it is not on the Computer at that time, re-submit the claim again. This reply is normal when making a call to Medicare asking about a claim. The shortest processing time to date this year is 59 days, the longest time is 87 days and this excludes the 3 PENDING CLAIMS.

When I spoke to Mr. Jeff Henson on the local Radio Station WNWS this past June, he said that each days mail received is opened and batched on that same day. The following day these batches are micro-filmed and then forwarded for processing. If this proceedure is being followed, then why does it take 3 months to complete a claim?

For example - on a 30 day month, having 20 or 21 actual working days, where are these claims? What is being done during these other 18 or 19 work days to get these claims handled? It has been told to me, time and time again, there is a 6 week back-log of claims to be processed. From what I have been told, it is difficult to comprehend how a 6 week back-log can be accumulated if daily proceedures are being maintained.

I feel there is a definite breakdown in the Medicare proceedures for handling these claims, due to- - -

#1 - Lack of proper training.
#2 - Inadequate emphasis put on the importance of the job.
#3 - Lost effeciency due to improper use of work time.
#4 - Not enough people to do the job.
#5 - Management is not supervising their respective units to the fullest capacity.

It is time we all see some definite changes and results in the operations of the Medicare offices. All Medicare recipients are entitled to these benefits and we ask for that which is rightly ours, no more or no less.

SUBMITTED BY: MRS. DOROTHY A. MORRISON
JULY 11, 1986

1984 SUMMARY OF MEDICARE CLAIMS
JACKSONVILLE, FLORIDA

MEDICARE NO. 266-28-7191-A
CHARLES D. MORRISON
800 CAPRI ST., APT. #403
CORAL GABLES, FLORIDA 33134
TEL. NO. (305) 446-1266

DATE OF CLAIM	AMOUNT	DATE CLAIM MAILED TO MEDICARE	DATE OF TEL. INQUIRIES	DATE CLAIM RE-SENT TO MEDICARE	DATE CLAIM COMPLETED MEDICARE	BC/BS	PROC. TIME (Days)
1/16/84	$90.00	2-14-84	none	none	2/24/84	3/5/84	19
2/1/84	85.00						
3/6/84	85.00	3-6-84	none	none	3/19/84	3/21/84	15*
4/10/84	175.00	4-10-84	5/10/84	5/11/84	5/15/84	5/24/84	44
5/11/84	85.00	5-11-84	none	none	5/24/84	6/16/84	36
6/12/84	85.00	6-13-84	6/30/84 7/3/84	7/3/84-cross filing errors	6/30/84	7/28/84	44
7/10/84	85.00	7-11-84	none	none	8/10/84	8/26/84	46
8/8/84	85.00	8-8-84	none	none	8/22/84	8/26/84	18
9/10/84	85.00	9-11-84	*10/5/84 *11/16/84 *12/10/84 * 1/3/85	*10/5/84 Request Review and omitted code	10/5/84 *1/8/85	10/15/84 *1/29/85	33 *116 *
10/9/84	145.00	10-10-84	none	none	10/25/84	11/1/84	21
10/10/84	50.00	10-10-84	none	none	10/25/84	11/1/84	21
11/12/84	85.00	11-16-84	none	none	12/15/85	12/31/84	45
12/11/84	85.00	12-11-84	none	none	1/8/85	1/13/85	33

TOTAL CLAIMS SUBMITTED TO MEDICARE - 12
TOTAL TELEPHONE INQUIRIES - 7
TOTAL CLAIMS SUBMITTED MORE THAN ONE TIME - 3

CLAIMS-NO INQUIRY NEEDED - 9
TOTAL NUMBER OF CLAIMS RE-SENT - 3

SHORTEST PROCESSING TIME - 15 DAYS*
LONGEST PROCESSING TIME -116 DAYS*

SUBMITTED BY MRS. DOROTHY A. MORRISON
JULY 11, 1986

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1985 SUMMARY OF MEDICARE CLAIMS
JACKSONVILLE, FLORIDA

MEDICARE NO. 266-28-7191-A
CHARLES D. MORRISON
800 CAPRI ST., APT. #403
CORAL GABLES, FLORIDA 33134
TEL. NO (305) 446-1266

DATE OF CLAIM	AMOUNT	DATE CLAIM MAILED TO MEDICARE	DATE OF TEL. INQUIRIES	DATE CLAIM RE-SENT TO MEDICARE	DATE CLAIM COMPLETED MEDICARE	BC/BS	PROC. TIME (Days)
1-8-85 2-6-85	$215.00	2-7-85	3-7-85 4-1-85 4-10-85 Letter to C.Pepper on 4-1-85 4-15-85	Cross-filing errors. handled by tel.calls	3-9-85	4-22-85	74
2-13-85 2-25-85	160.00	2-25-85	4-1-85 4-10-85 4-15-85	4-1-85 cross filing errors & omitted code for payment	3-30-85 5-1-85	4-1-85 5-6-85	70
2-28-85 3-12-85 3-13-85	540.00	3-13-85	4-10-85 5-28-85 6-17-85 6-21-85 6-24-85 6-27-85	4-30-85 omitted code for payment 6-10-85 cross filing errors	4-30-85 6-10-85	5-15-85 6-29-85	109
4-8-85	175.00	4-8-85	none	none	5-10-85	5-13-85	35
4-15-85 4-29-85	238.00	4-30-85	6-19-85 6-24-85 6-27-85 7-1-85 7-10-85	6-19-85LOST 7-5-85 LOST 7-18-85	8-13-85	8-17-85	109
5-6-85	119.00	5-6-85	6-24-85 6-27-85 8-12-85 8-26-85	*6-24-85 due to cross filing error	6-22-85 8-12-85*	7-1-85 9-7-85*	93
5-20-85	129.00	5-20-85	6-19-85 7-5-85 7-10-85 8-12-85 8-26-85 9-16-85	6-19-85LOST 6-29-85 to request review for one code 8-12-85 cross filing errors	6-29-85 9-22-85	7-3-85 9-26-85	98
6-3-85	244.00	6-3-85	7-11-85 8-26-85 9-16-85	6-19-85 LOST 7-18-85 to request review	7-11-85 9-20-85	7-15-85 9-26-85	115*

CONTINUED TO PAGE 2

PAGE 2

1985 SUMMARY OF MEDICARE CLAIMS
JACKSONVILLE, FLORIDA

DATE OF CLAIM	AMOUNT	DATE CLAIM MAILED TO MEDICARE	DATE OF TEL. INQUIRIES	DATE CLAIM RE-SENT TO MEDICARE	DATE CLAIM COMPLETED MEDICARE	BC/BS	PROC. TIME (Days)
6-4/5/-6/7/85 to Hospital 6-10-85	$519.00	6-10-85	6-19-85 LOST 7-10-85 8-13-85 8-26-85 9-16-85	6-19-85 7-5-85	7-20-85 8-26-85	7-25-85 9-21-85	103
6-19-85	119.00	6-19-85	7-5-85	7-5-85	8-26-85	8-29-85	71
6-28-85	109.00	6-29-85	none	none	7-20-85	7-25-85	26*
7-15-85	119.00	7-16-85	none	none	8-26-85	8-29-85	44
8-5-85	109.00	8-6-85	9-16-85	none	9-20-85	9-29-85	54
9-3-85	110.00	9-4-85	10-7-85 10-29-85	10-7-85 cross-file error	10-7-85	11-4-85	61
10-1-85	188.00	10-2-85	none	none	11-6-85	11-15-85	35
10-1-85 Ambulance to Hosp.	108.00	10-5-85	none	none	11-20-85	12-6-85	62
10-1thru 10-8-in Hosp.	750.00	10-29-85	none	none	12-23-85	12-30-85	62
10-14-85	110.00	10-15-85	none	none	11-20-85	12-6-85	52
10-28-85	154.00	10-29-85	none	none	12-18-85	12-23-85	55
11-18-85	109.00	11-19-85	none	none	1-13-86	1-16-86	58
12-9-85	109.00	12-10-85	none	none	2-6-86	2-17-86	69

TOTAL CLAIMS SUBMITTED TO MEDICARE - 21
TOTAL TELEPHONE INQUIRIES - 42
TOTAL CLAIMS SUBMITTED MORE THAN ONE TIME - 17

SHORTEST PROCESSING TIME - 26 DAYS *
LONGEST PROCESSING TIME - 115 DAYS *
CLAIMS-NO INQUIRY NEEDED - 11
TOTAL NUMBER OF RE-SENDS - 16

SUBMITTED BY MRS. DOROTHY A. MURRISON
JULY 11, 1986

1986 SUMMARY OF MEDICARE CLAIMS(To Date 7/86)
JACKSONVILLE, FLORIDA

MEDICARE NO. 266-28-7191-A
CHARLES D. MORRISON
800 CAPRI ST.,APT.#403
CORAL GABLES, FLORIDA 33134
TEL. NO. (305) 446-1266

DATE OF CLAIM	AMOUNT	DATE CLAIM MAILED TO MEDICARE	DATE OF TEL. INQUIRIES	DATE CLAIM RE-SENT TO MEDICARE	DATE CLAIM COMPLETED MEDICARE	BC/BS	PROC. TIME (Days)
1-6-86	$109.00	2-4-86	3-24-86	4-2-86	4-14-86	4-17-86	71
2-3-86	154.00		4-1-86	4-2-86			
			4-2-86				
			4-10-86				
3-3-86	109.00	3-3-86	4-2-86	4-2-86	4-26-86	5-1-86	59
			4-10-86				
3-31-86	109.00	4-1-86	4-12-86	4-12-86	6-26-86	6-27-86	87
			6-3-86	6-20-86			
			6-19-86				
			6-20-86				
4-28-86	254.00	4-28-86	6-20-86	6-20-86	STILL PENDING		73
			7-8-86				
5-27-86	109.00	5-27-86	6-20-86	6-20-86	STILL PENDING		44
6-23-86	109.00	6-23-86	none	none	STILL PENDING		17

TOTAL CLAIMS SUBMITTED TO MEDICARE - 6
TOTAL TELEPHONE INQUIRIES - 13
TOTAL CLAIMS SUBMITTED MORE THAN ONE TIME - 6

SHORTEST PROCESSING TIME,FROM 1/1/86 - 59 DAYS
THRU 7-1-86
LONGEST PROCESSING TIME,FROM 1/1/86 - 87 DAYS
THRU 7/1/86

SUBMITTED BY MRS. DOROTHY A. MORRISON
JULY 11, 1986

Dedicated to the health, beauty and safety of beloved pets...everywhere

PAKLORD
CORPORATION

July 11, 1986

The Honorable Claude Pepper
51 S.W. 1 Avenue
Miami, FL 33130

Dear Congressman Pepper:

I have not come here today to discuss historical problems with Medicare and its agent, Blue Cross: the inability to reach Blue Cross by telephone; disagreements over the amount of re-imbursement, especially for surgery and anesthesia; and similar problems.

Rather I am here today because Medicare's failure to pay claims in a timely manner is robbing senior Americans like myself, citizens without the financial resources to endure these delays.

As you know, very few doctors will take Medicare assignment. So far in 1986 I have paid out hundreds of dollars to doctors on the day of service yet have waited, on the average, more than 60 days to receive re-imbursement from Medicare. For example, I have a $130 claim pending with Medicare since May 8. This is for a simple office visit, x-rays and injections. When I telephoned Blue Cross on July 9 to inquire about the claim I was told that it had not been processed and that it would not be processed "until we get around to it."

The case of a physician who will accept Medicare assignment is equally shocking. I had surgery 120 days ago yet my physician, Dr. Mark Feldman, is still waiting for payment from Medicare. Medicare's failure to re-imburse physicians like Dr. Feldman in a timely manner jeopardizes their medical practice. If these doctors are no longer financially able to accept assignment, the last possibility of cost-saving medical care will be denied to patients like myself.

Congressional legislation should be enacted to insure that all claims are paid within 30 days. In the event that payment is withheld for more than 30 days, Medicare or Blue Cross should be required to pay interest to the beneficiary. When this policy was adopted by Congress with regard to IRS refunds, the refund process was speeded up immeasurably. Like any business, Medicare/Blue Cross must pay its obligations on time or be penalized for failing to do so.

Very truly yours,

Lillian Lampert

LL/d

P.O. Box 640272
Miami, Florida 33164
(305) 947-1440
16098 N.E. 9th Avenue
North Miami Beach, FL 33162

DIPLOMATES, AMERICAN BOARD OF CARDIOVASCULAR DISEASE

TELEPHONE (305) 531-7183

MORTON KORN, M.D., AND STEPHEN ZARON, M.D.
PROFESSIONAL ASSOCIATION
1688 MERIDIAN AVENUE
MIAMI BEACH, FLORIDA 33139

July 3, 1986

Melanie
c/o The Office of The Honorable Claude Pepper (D.-Fla.)
904 Federal Building
Miami, FL 33130

Dear Melanie:

I am writing to you in response to your request for information concerning problems with Medicare. What I am giving you is a list of claims which we have been able to quickly compile which are outstanding to our office, that is, most of this is assignment claims.

Most of our patients, however, pay us but, unfortunately, I cannot give you exact information about their claims. Hopefully, some of them will be go downtown to appear at the hearing. I know that the vast bulk of the problems that we have in our office is with non-assigned claims, i.e., with the patients who pay us and cannot get reimbursed.

The following list of problems that we have on assigned claims:

Lillian Goodman, 113-03-0316A, she had an emergency room visit on February 3, 1986, which we were late in filing, nevertheless, this assigned claim has not been paid.

Nathan Cohen, 079-01-1133A, Holter monitor, for which Medicare paid only $31.60 instead of $270. This payment was appealed on May 30, 1986, as of July 3, 1986, we have had no reply.

Florence Hollander, 292-28-8010A, services in the office on February 12, 1986, of $160, taken on assignment, no response from Medicare; re-filed on June 24, 1986.

Ted Kanov, 058-05-4777A, two rehabilitation visits, filed in 1985, a total of $96, assigned claim, re-filed February, 1986; we have heard nothing.

Irwin Kimche, 150-36-0455A, services on March 14, 1986, on assignment, $95, re-filed June 24, 1986; no reply.

Sol Marner, 125-10-2803A, services $170, dates March 15 and March 16, 1986, taken on assignment; no reply from Medicare.

David Metz, 055-12-2504A, services of April 11, 1986, filed that same day, amount of $72, nothing heard from Medicare.

Marvin Planner, 133-07-7286A, service March 11, 1985, Holter monitor March 25, 1985, amount $325, denied on April 26, 1985, appealed on that same day, no word on the appeal.

Dora Weissler, 110-07-5357B, services of April 18, 1986, amount $45, taken on assignment, no reply from Medicare.

Max Bernstein, 050-14-2573A, hospital charges dating back to March 1985, amount $1,443, filed non-assignment, no reimbursement to date.

Frances and Bernard Mishuris, 130-03-0917A and 130-03-0917B, charges for Bernard of $125 on October 29, 1985, and for Frances on the same date of $162, we accepted assignment, payment was made to the patients and we are unable to get the money back.

Thelma Leban, a non-assigned claim, hospitalization filed May 5, 1986; she has heard nothing.

Max Ditchek, 101-03-3607A, a hospitalization filed on January 27, 1986, amount $700, this was an assigned claim, re-filed on May 27, 1986, we have still received no payment.

As I indicated above, most of our claims are unassigned and, therefore, this really represents only a small sampling of the problems which our office and our patients are confronting.

We very much appreciate Congressman Pepper's interest in this very extensive and very destructive problem.

I fear that these claims will take six months to a year to resolve.

Once again, most of our claims are not assigned and, therefore, what I have given you above does not really reflect the problem that our patients have, but, surely, we thought something should have been done by this late date.

Sincerely,

MORTON KORN, M.D. 13831

STEPHEN ZARON, M.D. 51058

MK:SZ/ja

NATIONAL ASSOCIATION FOR HOME CARE

PRESS★RELEASE

FOR IMMEDIATE RELEASE

CONTACT: Liesel Flashenburg
(202) 547-5285
Howard Bedlin
(202) 547-7424

NAHC DECLARES MEDICARE DELAYS HURTING NATION'S ELDERLY

WASHINGTON, D.C---The National Association for Home Care (NAHC) released the results of a nationwide survey on medicare payment delays at a hearing in Miami, Florida on July 11 before Congressman Claude Pepper's Subcommittee on Health and Long Term Care of the House Select Committee on Aging. NAHC is the nation's largest association representing home care professionals and paraprofessionals. The survey found that home health agencies are suffering from extensive delays in Medicare payments which are having a serious negative impact on their ability to deliver needed services to Medicare patients.

With 380 agencies responding, the survey findings make it clear that Medicare beneficiaries throughout the country are not receiving fair treatment when it comes to having their home health bills paid promptly. In response to the survey of home care providers:

88 percent said that the average time it takes for Medicare to pay a claim is more than one month.

77 percent said that they had noticed an appreciable delay since September 1985 in the time it takes Medicare to pay a claim.

These delays have the following negative effects on the operations of home care providers:

- 59 percent incur additional administrative costs;
- 46 percent are unable to pay bills on time;
- 43 percent must borrow money;
- 27 percent are unable to meet their payroll;
- 15 percent are forced to reduce indigent care; and
- 10 percent are forced to reduce services to patients.

The survey also found that, during this disruptive period, many of the intermediaries responsible for paying the claims are turning their backs on home care providers. Approximately one-half of the survey respondents said that since January, their intermediary has been less responsive to inquiries about delayed payments, policy changes or manual changes.

According to NAHC President Val Halamandaris. "These purposeful delays on the part of the Department of Health and Human Services have been destructive and unacceptable. They have been driving home care providers out of business and have seriously undermined attempts to deliver services to the needy at home."

AARP NEWS

For further inquiry, contact: American Association of Retired Persons • Public Relations
1909 K Street, N.W. Washington, DC 20049 • (202) 728-4300

FOR IMMEDIATE RELEASE
July 11, 1986

CONTACT: Stephanie Kennan
(202) 728-4744

AARP SUPPORTS NEW MEDICARE CLAIMS PROCESSING POLICY

WASHINGTON, D.C. -- A new effort to accelerate the payment of Medicare claims, discussed today at a Congressional field hearing in Miami, is endorsed by the American Association of Retired Persons (AARP).

Florida Congressman Claude Pepper (D-18th) chaired the hearing, sponsored by the House Select Committee on Aging, which explored recent efforts by the Health Care Financing Administration to speed up the processing of Medicare claims.

The new HCFA policy seeks to process uncomplicated claims within 90 days. These "clean" claims--which make up about 70% of all claims--do not require medical review or additional information from beneficiaries or health providers. Some involve Medicare as a second payer.

AARP Executive Director Cyril F. Brickfield termed the new claims policy "a step in the right direction," noting that it will boost beneficiaries' confidence in Medicare and encourage physicians to accept Medicare payments as full reimbursement for their services to patients 65 and older.

He said, "AARP strongly supports efficient, timely and accurate processing of claims by Medicare contractors. We are pleased that HCFA has allocated proper funding to back its effort to handle claims more quickly."

With more than 23 million members nationwide, the American Association of Retired Persons is the nation's largest organization of Americans age 50 and older. Headquartered in Washington, D.C., the non-profit, non-partisan organization offers a wide range of membership benefits, legislative representation at federal and state levels, and education and community service programs carried out through a national network of volunteers and local chapters.

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